# CITY OF BALTIMORE

# HEALTH DEPT.

# BUREAU OF

# VITAL STATISTICS

# DEATHS

# BEGINNING 1940

EP 23607

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

# DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

Authorization No. 345

# REQUEST FOR RETENTION PERIOD

Department: Health

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Bureau: Vital Statistics

**Record Identification**

| 1. TITLE: | 2. Form No. if available | 3. Type—(cards, paper, etc.) |
|---|---|---|
| Certificate of Death | | Bound Book |

| 4. Dates | 5. Volume accumulated yearly | 6. Size of Record | 7. Number of copies made |
|---|---|---|---|
| | | Misc. | One (1) |

8. Authorization Requested (check only one (1) of the squares below)

A. ☐ Establish retention period for records which are accumulating daily.

B. ☐ Dispose of present accumulation, no additional accumulation anticipated.

C. ☐ Microfilm and destroy originals.

D. ☒ Microfilm and retain originals for length of time indicated below.

| 9. Recommended Retention Period a. In Dept. | b. In Storage Center | c. Total | 10. Equipment and space freed. | 11. In your opinion does this record have any historical significance? |
|---|---|---|---|---|
| 12 yrs. | Micro. Perm. | 12 yrs. and Micro. Perm. | | YES ☐ NO ☒ |

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval Robert E. Farber M.D Title: Commissioner of Health 3/28/63 Date

**Recommendation of Records Management Officer**

| 13. Recommended Retention Period a. In Dept. | b. In Storage Center | c. Total | 14. Disposal Method A. To be sold as scrap or waste paper | B. To be Burned or shredded | C. Historical, (to be transferred to Dept. of Legislative Reference.) |
|---|---|---|---|---|---|
| 12 yrs. | Microfilm Permanent | 12 yrs. and Microfilm Permanent | ☐ | ☒ | ☐ |

REMARKS:

C P Force 3/29/63
Records Management Officer Date

**APPROVALS OF RECORDS DISPOSAL COMMITTEE**

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER, ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

# FILED ON FILM

# IN

# NUMERICAL ORDER

G16001 G16001

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1428 Madison Ave
(c) Hospital or institution:

(d) Length of stay in ital or inst. (yrs., mos., or days)
(e) Length of stay in B. more (yrs., mos., or days) 25 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1428 Madison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME Virgil Bowers

(b) If veteran, name war WWI

3. (c) Social Security Account No. 213-07-7603

4. Sex M | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ida Bowers
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) 7-12-95

8. AGE: Years 51 | Months 4 | Days 16 | If less than one day hr. min.

9. Birthplace Chaplin, S.C.
(Town, county, and state)

10. Usual Occupation Steel worker

11. Industry or business Bethlehem Steel Corp.

FATHER
12. Name George Bowers
13. Birthplace S.C.

MOTHER
14. Maiden Name Agie Durett
15. Birthplace S.C.

16 (a) Informant Mrs. Ida Bowers
(b) Address 1429 Madison Ave.

17 (a) Burial (b) Date thereof 12-3-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Chaplin, S.C.

18 (a) Funeral director Charles L. Lane
(b) Address 802 Madison Ave

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Nov 24 1946, at 8:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 1946, to Nov 24 1946 and that I last saw h[illegible] alive on Nov 24 1946

Immediate cause of death: Cerebral apoplexy — Duration: 1 hr.
Due to: Hypertension — 12 yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jas. H. Pendleton M. D.
Address 1723 Druid Hill Ave

Undertaker

PLEASE write the cause of death in the correct space as expressly requested. Physicians: please write plainly.

VS NOV 29 1946

11-29-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G16003 / 184 Registered No. G1600[illegible]

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 212- Sollers Point Road. Dundalk (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** RICHARD D. MITCHEL

3 (b) If veteran, name war World War II

3 (c) Social Security Account No. 216-10-2954

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 24, 1926

8. AGE: Years 20 | Months 6 7 | Days 5 | If less than one day: hr. min.

9. Birthplace Dundalk, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Mitchell
13. Birthplace Virginia

MOTHER
14. Maiden Name Ella Jackson
15. Birthplace Virginia

16 (a) Informant James Mitchel
(b) Address 212 Sollers Pt. Rd. Dundalk

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/46 (month) (day) (year)
(c) Cemetery or crematory Maryvale Cem. Location Frederick Rd.

18 (a) Funeral director Charles R Law
(b) Address 812 Madison Ave.

19 (a) (Date rec'd by registrar) NOV 29 1946 (b) Huntington Williams Registrar

VS 181

**MEDICAL CERTIFICATION** 8:59 P.M.

**20. DATE OF DEATH** Nov. 29, 1946, at 2:59 P.M.

**21.** I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wound of abdomen
involving mesentery & small intestines
Due to
Other Conditions
(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 11:40PM 53-05
(a) Date of injury 11-29-46 at 1:2[illegible] P.M.
(b) Where did injury occur? 204 Avondale Rd. Dundalk
(c) Did injury occur at home, on farm, industrial place, in public place? (home) While at work? No
(d) Means of injury Firearms- gunshot wound

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 11-29-46

×

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16003

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94R

Registered No. G16003

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Rear 1228 Greenmount avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County ---
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 Barclay street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** DAVID F. McCLISH

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | 215-05-7369 |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Agnes A. McClish
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) May 4, 1893

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | 6 | 22 | hr. min. |

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation Boiler Maker
11. Industry or business

FATHER
12. Name Ambrose McClish
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary Conkel
15. Birthplace Unknown

16 (a) Informant Mrs. Agnes A. McClish
(b) Address 1120 Barclay street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/46 (month) (day) (year)
(c) Cemetery or crematory Lotherdale
Location
18 (a) Funeral director Chas. J. Evans & Son Inc.
(b) Address 118 N. Mt. Royal Ave
19 NOV 29 1946 (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Nov. 26 1946, at M
21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1946, to 26 Nov 1946, and that I last saw h alive on 24 Sept 1946

| Immediate cause of death | Duration |
|---|---|
| Coronary thrombosis | 5-10 Minutes |
| Due to Coronary Disease of the Heart | 3 mos. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Samuel Silverfield M. D.
Address 714 E. Preston Date signed 29 Nov 1946

Statement by Registrar

VS 150

For Dr. C. J. Lubinski, by Howard J. Cummins, M.D.

G16001

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1317

Registered No. G1600

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 237 S. East Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 237 S. East Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Mary Rogers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed.

6 (b) Name of husband or wife Michael Rogers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-5-1859

8. AGE: Years 87 | Months 0 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Michael Cahan
13. Birthplace Ireland.

MOTHER
14. Maiden Name Johanna (unknown)
15. Birthplace

16 (a) Informant Michael Rogers
(b) Address 237 S East Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 30 46.
(month) (day) (year)
(c) Cemetery or crematory Cathedral, New.
Location Old Frederick Rd.

18 (a) Funeral director Kelly & Geisler Inc
(b) Address 403 N. Wolfe St.

19 (a) NOV 29 1946 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

45

20. DATE OF DEATH November 27, 1946, at 12 P. M.

21. I certify that I took charge of the remains described above, held an Inspection & Enquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to

Other Conditions Cardio-vascular renal disease

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mahoney M.D.
Medical Examiner.
Date signed 11-27-46

X

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G15005

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

G15005

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2106 Bank St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2106 Bank St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** WALTER DEMBECK

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Helen Welzant
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-8-1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 4 | 20 | hr. min. |

9. Birthplace West Prussia
(Town, county, and state)
10. Usual Occupation Groceryman
11. Industry or business Self

FATHER
12. Name Frank Dembeck
13. Birthplace West Prussia

MOTHER
14. Maiden Name ~~Ann~~ (Unknown)
15. Birthplace

16 (a) Informant Helen Dembeck
(b) Address 2106 Bank St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 2 46 (month) (day) (year)
(c) Cemetery or crematory St. Stainislaus
Location 1300 Dundalk Ave

18 (a) Funeral director Lilly & Zeiler Inc
(b) Address 403 S. Wolfe St.

19 (a) 1946 (Date rec'd by registrar) (b) Clinton Williams, M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Nov. 26, 1946 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21 1946, to Nov. 28 1946, and that I last saw h[illegible] alive on Nov. 27 1946.

| Immediate cause of death | Duration |
|---|---|
| Hypertensive Cardio Vascular Disease | |
| Due to Arteriosclerosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Tinsworth M. D.
Address 2549 Fenton Ave. Date signed

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16005

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G16005 Registered No. V 838

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3102 Woodland Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3102 Woodland Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Alice Michael,

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single, |

6 (b) Name of husband or wife ----

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 11 | 22 | hr. min. |

9. Birthplace Pikesville, Balto. Co. Md.,
(Town, county, and state)
10. Usual Occupation Housekeeper,
11. Industry or business at hom e,

FATHER
12. Name George H. Michael,
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name Mary C. Leonard,
15. Birthplace County Cork, Ireland.

16 (a) Informant Miss Gertrude Michael,
(b) Address 3102 Woodland Ave.,

17 (a) Burial, (b) Date thereof 11/30/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.,
Location Baltimore City.

18 (a) Funeral director C. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M. D. Registrar

NOV 29 1946

V S 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Nov. 27, 1946 at 1. A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 26 1946 to 11/27/1946 and that I last saw h er alive on 11/27/1946

Immediate cause of death Cerebral Hemorrhage — Duration 11/26/46

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos A Dubert M. D.
Address 4803 Park Heights Date signed 11/29/46

AB-105105

G16007

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G16007 Registered No.

RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo. & 19days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:** 547
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 929 Quantril Way-Arms Apts (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Margaret Wilkinson-or- Margaret Wilkerson

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Divorced |

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8- 1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | 9 | 19 | hr. min. |

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Pugh
13. Birthplace Maryland

MOTHER
14. Maiden Name Josephine Weber
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/46 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Old Frederick Rd

18 (a) Funeral director Laurence F. Hoffman
(b) Address 1639 Broadway

19 (a) (Date rec'd by registrar) 1946 (b) Huntingtown Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1946, at 1:25 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-8- 1946, to 11-27 1946, and that I last saw h er alive on 11-27 1946

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions Coronary sclerosis. C.P.C. Liver & kidneys. Glioma left parietal lobe (Include pregnancy within 3 months of death)

Date of operation 11/15/46

Major findings of operation: Infiltrating glioma of left parietal lobe brain

of autopsy As above.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. H. Gibbs M. D.
Address Baltimore City Hosp Date signed 11/27/46

505 110. G16008 BC# D62403 BALTIMORE CITY HEALTH DEPARTMENT G16008 Registered No.

# CERTIFICATE OF DEATH V/160 A

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 330 S Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy Neville Edmond Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-22-46 5:50 A.M.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 6 7 | hr. min. |

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edmund Neville
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mildred Rhoads
15. Birthplace Baltimore, Md.

16 (a) Informant Friend
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/46 (month) (day) (year)
(c) Cemetery or Crematory New Cathedral
Location 4300 Old Frederick Rd. Balto. Md

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison St.

19 (a) NOV 29 1946 (Date rec'd by registrar) (b) Huntington for Williams M.D. Registrar

**MEDICAL CERTIFICATION** A.

20. DATE OF DEATH Nov-29 1946 at 2.35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 22 1946, to Nov 29 1946, and that I last saw him alive on Nov 29 1946.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Prematurity & intracranial hemorrhage | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at P.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Barton Childs M.D.
Address Johns Hopkins Hosp. Date signed 11-30-46

VS 150

X

G16009 BCH BALTIMORE CITY HEALTH DEPARTMENT G16009

G 61990 CERTIFICATE OF DEATH 159 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2416 N. Howard St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Martin
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race Black
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11-15-46
8. AGE: Years Months Days 7 If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Joe Harris
13. Birthplace S.C.
MOTHER 14. Maiden Name Ida Martin
15. Birthplace Ga.
16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 29 1946
18 (a) Funeral director Commissioner of Health
(b) Address
19 (a) NOV 29 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Nov. 23 1946, at 1 30 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 16 1946 to Nov 23 1946 and that I last saw him alive on Nov. 23 1946.
Immediate cause of death PRE MATURITY — Duration WEE
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Paul H. Harding M. D.
Address Johns Hopkins Hosp. Date signed 11/24/46

VS 150

G16010 — BALTIMORE CITY HEALTH DEPARTMENT — G16010

# CERTIFICATE OF DEATH 195 C

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division St - 17
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1426 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ernest Pattus

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lottie Pattus
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 12, 1904
8. AGE: Years 42 | Months 1 | Days 13 | If less than one day hr. min.
9. Birthplace Chase City, Va (Town, county, and state)
10. Usual Occupation Car Cleaner
11. Industry or business

FATHER
12. Name Samuel Pattus
13. Birthplace Chase City, Va

MOTHER
14. Maiden Name Lottie Adam
15. Birthplace Charlotte C. Va

16 (a) Informant Mrs. Lottie Pattus
(b) Address 1426 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29, 1946 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md.

18 (a) Funeral director George H. Holland
(b) Address 1631 Druid Hill Ave

19 (a) NOV 29 1946 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH November 25 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1946 to Nov. 25 1946, and that I last saw h alive on Nov. 25 1946.

| | Duration |
|---|---|
| Immediate cause of death acute cardiac decompensation | 45 hrs. |
| Due to primary atypical pneumonia (virus pneumonia) | 10 days |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James D. Carr, M. D.
Address 515 Morton St Date signed 11.27.46

VS 3

G16011 G16011

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1314 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3413 Brentwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3413 Brentwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** James Henry Lee Jones

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Widower |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 26, 1864

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | 1 | 1 | hr. min. |

9. Birthplace Va
(Town, county, and state)
10. Usual Occupation Lumberman
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Verneal Delaney
(b) Address 3413 Brentwood Ave
17 (a) Removal (b) Date thereof Nov 29/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Brownsville Pa.
18 (a) Funeral director Mrs. Robert A. Elliott Dept
(b) Address 1129 N. Carlin St.
19 (a) (b) Huntington Williams Mgr
(Date filed by registrar) Huntington Williams, Md.

NOV 29 1946

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Nov 27, 1946 at 1:45 a M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan, 1946 to Nov 26, 1946 and that I last saw him, alive on Nov 27, 1946.

| | Duration |
|---|---|
| Immediate cause of death Coronary Thrombosis (Final disease) | 2 mo. |
| Due to Arteriosclerosis | 5 yrs. |
| Due to Chronic Nephritis | 5 yrs. |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury
23. Signature Wm. H. Baumgartner
Address 2740 St. Paul St. Date signed Nov 29, 1946

MARGIN RESERVED FOR BINDING
LEGIBLE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G46012

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1930

Registered No. G46012

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2108 W. Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2108 W. Fayette St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** THERESA MAE CULVER

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No.:

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: Francis E. Culver

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1897

8. AGE: Years 49 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace NEW YORK (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name Albert Osborne
13. Birthplace NEW YORK

MOTHER
14. Maiden Name Katherine Yatto
15. Birthplace NEW YORK

16 (a) Informant FRANCIS E. CULVER
(b) Address 2108 W. Fayette St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-2-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave.

NOV 30 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 28, 1946, at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to 11/28 1946, and that I last saw her alive on 11/28 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration 11/28/46

Due to: Hypertensive Cardio-Vascular Disease — 3 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 366 E. Edmondson Date signed 11/29/46 M.D.

G46013

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1948

G46013 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St
(c) Hospital or institution: St Joseph Hospital Baltimore Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3419 Kenyon Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Albert M. Daley

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-3880

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | White | Married |

6 (b) Name of husband or wife Elizabeth Sophie Daley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 26 1897

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 49 | 3 | 3 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Gas & Electric Co.

FATHER
12. Name Jacob Daley
13. Birthplace Maryland

MOTHER
14. Maiden Name Ida Gruver
15. Birthplace Maryland

16 (a) Informant Elizabeth Sophie Daley
(b) Address 3419 Kenyon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-46 (month) (day) (year)
(c) Cemetery or crematory Parkwood Maryland
Location

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave.

19 (a) NOV 30 1946 (Date rec'd by registrar) (b) Burington Willis Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1946, at 7.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 26 1946 to Nov 29 1946, and that I last saw him alive on Nov 29 1946.

| Immediate cause of death | Cardiac Respiratory Failure | Duration |
|---|---|---|
| Due to | Coronary Thrombosis | |
| Due to | Coronary arteriosclerosis Heart disease years each | |
| Other Conditions | Essential Hypertension (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation: Coronary Thrombosis; anterior descending branch.
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 11/30/46

VS 150

G46014

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

Registered No. G46014

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Woodlawn, Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ridge Road "7"
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

**3 (a) FULL NAME** Florence Kromatis

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband ~~or wife~~ Angelo Kromatis
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name George W. Jennings
13. Birthplace Maryland

MOTHER
14. Maiden Name Hannah Smith
15. Birthplace Deal Is., Md.

16 (a) Informant Angelo Kromatis
(b) Address Woodlawn, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 2, 1946 (month) (day) (year)
(c) Cemetery or crematory Lakewood Cem.
Location Catonsville Md.

18 (a) Funeral director Geo. Pattison & Son
(b) Address Ellicott City, Md.

19 (a) NOV 30 1946 (Date rec'd by registrar) (b) Arlington Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11-29 1946, at 8:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-19 1946 to 11-29 1946.
and that I last saw her alive on 11-29 1946.

Immediate cause of death Chemical Pneumonia due to Septicemia

Due to —

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —

of autopsy: —

| Duration |
|---|
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature L. Eshiggo, M.D.
M. D.
Address Univ. Hosp. Date signed 11-29-46

VS 150

X

G16015

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 93D

Registered No. G16015

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland 33rd + Calvert Sts
(b) Street address ~~1 A C St Hartford Rd~~
(c) Hospital or institution:
Union Memorial Hosp. (Accident Room)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 minutes
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2204 old Hartford Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** MRS. ANNA A. MATTHEW McCLELLAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband Matthew McClellan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 21st 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 8 | 8 | hr. min. |

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER 12. Name ? Korberle

13. Birthplace Germany

MOTHER 14. Maiden Name ? Korberle

15. Birthplace Germany

16 (a) Informant Tamzo M. McClellan

(b) Address Star Route #1, Salem N.J.

17 (a) Removal (b) Date thereof 11/30/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Presbyterian
Location Hollidaysburg Pa.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St Paul

19 (a) NOV 30 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Nov. 29 1946, at 10 15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from MAY -6 1946 to NOV. 29 1946 and that I last saw h.EM. alive on NOV. 29 1946

Immediate cause of death: ACUTE PULMONARY EDEMA — Duration: 30 MIN.

Due to HYPERTENSIVE CARDIO-VASCULAR — 10 YRS.

Due to DISEASE

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? HOSPITAL While at work? (Specify type of place)
(e) Means of injury

23. Signature Stuart D. Sunday

Address 201 C. 33rd St. Date signed 11/30/46

VS 150

Stuart D. Sunday

MARGIN RESERVED FOR BINDING.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46016

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G46016

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5000 Cordelia Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 yrs 18 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 5000 Cordelia Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John George Schreiner

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

| 4. Sex | 5. Color or race | 6 (a) Single, married, ~~widowed, or divorced~~ |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife (Mary) E. Schreiner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 9th 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 8 | 19 | hr. min. |

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Car Inspector
11. Industry or business B & O R. R.

FATHER
12. Name Charles Schreiner
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Thelda Derr
(b) Address 5000 Cordelia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) DEC 0 1946 (Date rec'd by registrar) (d) Huntingtown Williamsport Md

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28th 1946, at 1 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946, to Nov. 28 1946, and that I last saw ~~him~~ her alive on 11-25 1946.

Immediate cause of death Bronchiogenic carcinoma of lung — Duration 8 mos.
Due to
Due to
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature J. Owen Moore M. D.
Address 3105 Bolan Rd Date signed 11-29-46

VS 150

G46017

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83A

Registered No. G46017

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 6000 Belona Ave
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. Edgewood Nursing Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Katherine Gleason

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 1st 1856

8. AGE: Years 89 | Months 11 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Patient

11. Industry or business Nursing Home

FATHER
12. Name Thomas Gleason
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Barry
15. Birthplace Ireland

16 (a) Informant Thomas F. Rossen
(b) Address 309 Title Building

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/46 (month) (day) (year)
(c) Cemetery or crematory St. Josephs
Location Texas Md

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 NOV 30 1946 (Date rec'd by registrar) (b) Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Nov 28th 1946, at 11:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1946 to Nov 28 1946 and that I last saw he alive on Nov 28 1946

Immediate cause of death: Paralysis — Duration: 4 yrs 4 mos

Due to

Due to

Other Conditions: Cerebral Haemorrhage (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ed Richardson M.D.
Address 117 W. 20th St. Date signed Dec 1 1946

VS 150

G46018

AB- 105767

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 93D

Registered No. G46018

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 2 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26days
(e) Length of stay in Baltimore (yrs., mos., or days) 38yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2039 E. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Malicki (Also known as Thomas Maleski)

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-3387

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Agatha Malicka

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25- 1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 10 | 3 | hr. min. |

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Malicki
13. Birthplace Poland

MOTHER
14. Maiden Name Kasie ?
15. Birthplace Poland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-46 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem
Location Balto County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) NOV 30 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28- 19 46, at 8:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2- 19 46 to 11-28 19 46, and that I last saw h. in alive on 11-28- 19 46.

Immediate cause of death Acute Heart Failure — Duration 1 Day

Due to Intrinsic Arterio Sclerotic Heart Disease — years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.
Address Balt. City, Md. Date signed 11/29/46

VS 150

G46019

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 52 A

Registered No. G46019

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1924 Brunt St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-3
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1924 Brunt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lillie Carr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert Carr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1891

8. AGE: Years 55 | Months 10 | Days | If less than one day hr. min.

9. Birthplace St. Marys Co. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ?
13. Birthplace St. Marys Co. Md.

MOTHER
14. Maiden Name Katie Milburn
15. Birthplace St. Marys Co. Md.

16 (a) Informant Lillie Henson
(b) Address 1924 Brunt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 30/946 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location

18 (a) Funeral director Mrs. Katie R. Williams
Address 2342 W. Saratoga St.

19 (a) NOV 30 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 11-26 1946, at 5P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1946 to 11-26 1946, and that I last saw h alive on 11-26 1946

Immediate cause of death Malignant Tumor of Kidney — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ben Thoms M. D.
Address 1207 N Carlton St. Date signed 11/30/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 186

G46020

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

157E

Registered No. G46020

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County A a. Co.
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Deborah Welborn
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11-2-46
8. AGE: Years Months Days 27 If less than one day 3 wks hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Welborn
13. Birthplace Miss

MOTHER
14. Maiden Name Cynthia Edrington
15. Birthplace Tenn

16 (a) Informant Respons.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 2/46 (month) (day) (year)
(c) Cemetery or crematory National Cemy.
Location Annapolis Md

18 (a) Funeral director John D. Mitchell & Son
(b) Address 1900 Eastern Place

19 (a) (Signature of registrar) per Entitz for Williams M.D. Registrar

NOV 30 1946

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1946, at 11 50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1946, to Nov 29 1946 and that I last saw her alive on Nov 29 1946.

Immediate cause of death Congenital Heart disease. — Duration Life

Due to

Due to

Other Conditions Transposition of great vessels. Patent ductus arteriosus.
(Include pregnancy within 3 months of death)

Date of operation 11/29/46

Major findings of operation:

of autopsy As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry E. Bahmon M. D.
Address Johns Hopkins Hosp Date signed 11/29/46

G46021

AB-106436

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

Registered No. G46021

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1906 Sulvgrave Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Howard Myerly

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary Finnegan Myerly
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 5- 1872

8. AGE: Years: 74 | Months: 7 | Days: 24 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Labor-Farm
11. Industry or business:

FATHER
12. Name: William Myerly
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Sarah A. Fuhrman
15. Birthplace: Maryland

16 (a) Informant: Baltimore City Hospitals Record
(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec 2 1946 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville Md

18 (a) Funeral director: Wm Berryman & Sons
(b) Address: Reisterstown Md

19 (Date rec'd by registrar): NOV 30 1946 (b) Huntington for Williams M.D. Registrar

## MEDICAL CERTIFICATION AM

20. DATE OF DEATH: November 29 1946, at 2.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27- 1946, to 11-29 1946, and that I last saw him alive on 11-29 1946.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to: Bronchopneumonia | |
| Due to: | |
| Other Conditions: A S C V D | |

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: Bronchopneumonia

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: W. Doyle Wardon M. D.
Address: B C H. Date signed: 11/29/46

VS 150

107-0

G46022

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

837

Registered No. G46022

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 16 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 425 N. Exeter St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Moyes Benedek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1871

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace — (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name — Unknown
13. Birthplace

MOTHER
14. Maiden Name — Unknown
15. Birthplace

16 (a) Informant Joseph Di Giorgio
(b) Address 429 (½) N. Exeter St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 1 - 1946 (month) (day) (year)
(c) Cemetery or crematory Govans Presbyterian
Location Bellona Ave and Balto Md

18 (a) Funeral director Joseph Lanasa Inc.
(b) Address 2013 Greenmount Ave

19 NOV 30 1946 (Date rec'd by registrar) Thomas J. Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 11-28 1946, at 7.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-16 1946 to 11-28 1946, and that I last saw him alive on 11-25 1946

| Immediate cause of death | Duration |
|---|---|
| Cardio resp. failure | |
| Due to Cerebral hemorrhage | |
| Due to arteriosclerosis | 5 |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E May M. D.
Address Calvert & Saratoga Sts. Date signed 11-28-46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46023 FINCHER

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13B

Registered No. G46023

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1800 Druid Hill
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 14-3
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1800 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Glenn Fincher

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | Col | Married |

6 (b) Name of husband or wife Rosie Fincher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23 1904

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 42 | 9 | 3 | hr. min. |

9. Birthplace SC (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

| | |
|---|---|
| FATHER | 12. Name Charles Fincher |
| | 13. Birthplace SC |
| MOTHER | 14. Maiden Name Nannie Jones |
| | 15. Birthplace SC |

16 (a) Informant Mrs Mathews
(b) Address Owner

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. D. Nelson
(b) Address 1303 Pennsylvania Ave

19 NOV 30 1946 (Date rec'd by registrar) Interment in Williamsport, Md.

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Nov. 26 1946, at 2 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Oct. 25 1946, to Nov. 26 1946, and that I last saw him alive on Nov 26 1946.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Tuberculosis | 3 mo |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23. Signature** Geo. McDonald M. D.
Address 464 N Carey Date signed 11/29/46

VS 150

G46024

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

Registered No. G46024

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2244 Wilkens Ave
(c) Hospital or institution:
201
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2244 Wilkens Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Conrad Bernhard Jr.

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 218-09-2157

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. ? 1882

8. AGE: Years 64 | Months 10 | Days ? | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Bookkeeper

11. Industry or business Lord Baltimore Hotel

FATHER
12. Name Conrad Bernhard, Sr.
13. Birthplace Germany

MOTHER
14. Maiden Name Jeanette Wolf
15. Birthplace Md.

16 (a) Informant Mrs. Audrey May Marshall, daughter
(b) Address 2244 Wilkens Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/46 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 30 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1946, at 4:45 M

21. I certify that I took charge of the remains described above, held an Aug Ed Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Helfrich M.D. Medical Examiner
Date signed 29 Nov '46

G46025

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

93D

Registered No. G46025

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2707 Parkwood Ave.
(c) Hospital or institution:

13-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2707 Parkwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** WILLIAM A. DOBYNS

3 (b) If veteran, name war: no

3 (c) Social Security Account No. no

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Emily B. Dobyns

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 3 | 3 | hr. min. |

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Edwin L. Dobyns
13. Birthplace Va.

MOTHER
14. Maiden Name M. Catherine Sanders
15. Birthplace Lancaster Co., Va.

16 (a) Informant Mrs. William H. Rimmey
(b) Address 2707 Parkwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 NOV 30 1946 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1946, at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 27 1945 to Nov. 27 1946 and that I last saw h[illegible] alive on Nov. 27, 1946.

| Immediate cause of death | Duration |
|---|---|
| Myocarditis (Chronic) | 1 year |
| Due to Arteriosclerosis | 2 " |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene K. Levasino M. D.
Address 514 Drury Lane Date signed 11/29/46

X

G46026

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH, 55 E

Registered No. G46026

CBK 106042

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 Years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 E. Lombard Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Prokop Woron

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8-1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | 10 | 13 | hr. min. |

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Woron
13. Birthplace Poland

MOTHER
14. Maiden Name Olena Colina
15. Birthplace Poland

16 (a) Informant Records-Balto. Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (burial, cremation, or removal) (b) Date thereof 11/23/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Ralph Rinn
(b) Address 1008 E. Fayette St.

19 (a) 11/20/46 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH November 21 1946, at 7:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12 1946, to Nov. 21 1946, and that I last saw h[illegible] alive on Nov. 21 1946

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Definite Cause unknown | |
| Due to | |
| Other Conditions Hypertensive cardiovascular disease (Include pregnancy within 3 months of death) | |

Date of operation 11/[illegible]/46
Major findings of operation Carcinoma of [illegible] Carcinoma, left arm
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. Doyle Waldron M. D.
Address 8 E. 7 Date signed 11/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

VS 150

G46027 BC# G4507

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

6 ✓

Registered No. G46027

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1211 Light St
(c) Hospital or institution: So Balto Gen Hosp 25-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 10 mos?

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4037 Guilford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

**3 (a) FULL NAME** Phillis Wentworth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 11 1946 1/11/46

8. AGE: Years 10 Months Days 19 If less than one day hr. min.

9. Birthplace Balto, Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Melvin Wentworth

13. Birthplace Baltimore

MOTHER 14. Maiden Name Louise Dream

15. Birthplace Baltimore Md

16 (a) Informant Mrs M Wentworth

(b) Address 4037 Guilford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/46 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Ritchie Highway

18 (a) Funeral director L J Dorsey & Son

(b) Address 1611 Light St.

19 NOV 30 1946 (Date received by registrar) Thurlow Weems Williamson, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11-30-46 1946, at 4:20 PM A

21. I certify that death occurred on the date above stated; that I attended deceased from 11-29 1946 to 11-30 1946 and that I last saw h[illegible] alive on 11-30 1946

Immediate cause of death Epidemic meningitis

| | Duration |
|---|---|
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G Brooke Wentworth M. D.

Address 1211 Light St Date signed 11-30-46

VS 150

G46028

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 30D

Registration No. G46028

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution:
Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 42 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5104 Hartford Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Clarence A. Kries

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | SEPARATED |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15, 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 3 | 13 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Pres. of Kries Co.
11. Industry or business Industry

FATHER
12. Name Mr. Henry Kries
13. Birthplace Balto.

MOTHER
14. Maiden Name Anne E Pottee
15. Birthplace Balto.

16 (a) Informant SAMUEL KISS SAPERO
(b) Address FOUNTAIN BLDG.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto

18 (a) Funeral director Leonard J. Kuck
(b) Address 5305 Harford Rd.

NOV 30 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Nov. 29 1946, at 7 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to Nov 1946 and that I last saw him alive on Nov 29 1946

| Immediate cause of death | Duration |
|---|---|
| Circulatory Failure | |
| Due to Ruptured Aortic Aneurism | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James V. Mercer, Jr. M.D.
Address Mercy Hospital Date signed 11/28/46

VS 150

G46029

Dr. Groosfeld

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94A

Registered No. G46029

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5604 Greenhill Avenue
(c) Hospital or institution:
26-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5604 Greenhill Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Edmond J. Canuel

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Rosa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 2, 1903

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 43 | 8 | 25 | hr. min. |

9. Birthplace Fall River, Mass. (Town, county, and state)
10. Usual Occupation Meat Inspector
11. Industry or business U.S. Government

FATHER
12. Name John B. Canuel
13. Birthplace Canada

MOTHER
14. Maiden Name Sophia Charette
15. Birthplace Maine

16 (a) Informant Mrs. Rosa Canuel
(b) Address 5604 Greenhill Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

NOV 30 1946 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1946 at 2:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1946 to Nov 27 1946 and that I last saw him alive on 11-27 1946

Immediate cause of death Coronary Occlusion — Duration

Due to Acute Nephritis — 2 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Victor Groosfeld M.D.
Address 5401 Belair Rd Date signed 12-2-46

VS 150

X

G46030 B.C.J. 62970 BERGER

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159 ✓

Registered No. G46030

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2317 E Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Girl Berger

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 25 Nov 46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 1 3/3 | hr. min. |

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Melvin Berger
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ruby May Craycraft
15. Birthplace Macon Mich.

16 (a) Informant Mother
(b) Address 2317 E. Preston St

17 (a) Burial (b) Date thereof 11-30-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Red.
Location Balto.

18 (a) Funeral director J. J. Ruck
(b) Address 5305 Harford Rd.

19 (a) NOV 30 1946 (Date rec'd by registrar) Lexington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Nov 27 1946, at 3:45 AM

**21.** I certify that death occurred on the date above stated; that I attended deceased from 25 Nov 1946, to 27 Nov 1946, and that I last saw he(R) alive on Nov 27 1946.

| Immediate cause of death | Duration |
|---|---|
| Atelectasis | |
| Due to (Premature 32 wks | |
| Due to Gestation) | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry T. Wilson Jr. M. D.
Address St. Joseph's Hosp. Date signed 29 Nov 46

X

G46031

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

549

Registered No. G46031

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address 4113 Marx Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4113 Marx Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** CLAIRE B. POTEE

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | single |

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1931

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 15 | 4 | 9 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER

12. Name Thomas I. Potee

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Elsa Kossman

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Thomas I. Potee

(b) Address 4113 Marx Ave., Balto. 6, Md.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Dec. 2, 1946 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Baltimore, Md.

18 (a) Funeral director Lasseter Funeral Home

(b) Address 7401 Belair Road Overlea, Md.

19 (a) Nov 30 1946 (Date received by registrar) (b) Timothy Jon Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH November 28, 1946, at 11:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22 1942 to Nov. 28 1946 and that I last saw her alive on Nov. 27th 1946 1 P.M.

Immediate cause of death Coma — Duration Nov. 1942

Due to Glioma, brain. — to Nov. 1946

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Henry Ivan Nuttall M. D.

Address 1229 N. Calvert St. Date signed Nov. 30, 1946

VS 150

G46032

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 448

Registered No. G46032 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 806 S. Sharp St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 806 S. Sharp St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie A. Dixon

3 (b) If veteran, name war (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Arthur H. Dixon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 46 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Charles W. Boone
13. Birthplace md.

MOTHER 14. Maiden Name Maggie Boone
15. Birthplace Md

16 (a) Informant Arthur H. Dixon
(b) Address 806 S. Sharp St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly ave

NOV 30 1946 (Date received by local registrar) Huntington Williams, M.D. Registrar

VS 150

11/27/46

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 11-27- 1946, at 9:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2, 1946, to Nov. 27, 1946, and that I last saw h[illegible] alive on Nov 27 1946.

Immediate cause of death Carcinoma of uterus — Duration 14 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John E. S. Campbell M. D.
Address 639 N. Carey Date signed 11-29-46

X

G46033

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

93D

Registered No. G46033

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 407 Furrow Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-5
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 407 Furrow Street (If rural give location)
(e) Citizen of foreign country? No a. (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARGARET SCHAEFER

3 (b) If veteran, name war ---------
3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Michael Schaefer
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) 12/14/1862

8. AGE: Years 83 | Months 11 | Days 13 | If less than one day: ********** hr. ********** min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife at
11. Industry or business Home

FATHER
12. Name John Winter
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Mary Kuester
(b) Address 407 Furrow Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 30 Nov. 46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Maryland

18 (a) Funeral director C. D. Nitsch & Sons
(b) Address 1300 Eutaw Place..17..

19 NOV 30 1946 (Date received by registrar) Huntington Williams M.D. (Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 27 November 1946 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1946 to Nov 27 1946 and that I last saw her alive on Nov 26 1946

Immediate cause of death Pulmonary Oedema — Duration

Due to: Cardiac Decompensation

Due to: Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norbert C. Nitsch M. D.
Address 2151 Wilkens Ave Date signed 11/27/46

X Dr. Norbert Nitsch Sr.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46034 G60722 BCH

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

160 R

Registered No. G46034

TB. 105699

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 804 S. Hanover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy Bethune ( Bertha

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct.30/1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 11 days | hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Dennis Bethune
13. Birthplace Ala.

MOTHER
14. Maiden Name Bertha Sanders
15. Birthplace Ala.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records

17 (a) Cremation (b) Date thereof Nov 21- 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Crematory
Location 4940 Eastern avenue.

18 (a) Funeral director
(b) Address

19 NOV 30 1946 (b) Huntington Williams, M.D.
Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Nov/11/46 at 2.05 P M M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct.30/ 1946 to Nov. 11 1946 and that I last saw h im alive on Nov. 11 1946

Immediate cause of death Pneumonia — Duration 2 days

Due to

Due to

Other Conditions Prematurity Cerebral Hemorrhage? — 12 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julian P. Griffin

Address Balt. City Hosps. Date signed 11/12/46

VS 150

107

G46035 BC# G61369

CWK-105919

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46035
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 E. Chase Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Knight, (Dora)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 7-1946

8. AGE: Years | Months | Days: 11 | If less than one day: hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alexander Knight
13. Birthplace Virginia

MOTHER
14. Maiden Name Dora Best
15. Birthplace North Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Nov 21-1946 (month) (day) (year)
(c) Cemetery or crematory Crematory
Location 4940 Eastern avenue

18 (a) Funeral director
(b) Address

19 (a) NOV 30 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18 1946, at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 1946, to Nov. 18 1946, and that I last saw her alive on Nov. 18 1946.

Immediate cause of death: Prematurity — Duration: life

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Alan E. Hughes M. D.
Address Balto City Hosp Date signed Nov. 24, 46

VS 150

G46036

BALTIMORE CITY HEALTH DEPARTMENT G46036

# CERTIFICATE OF DEATH

Registered No. 1258

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 812 China Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 812 China Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Parker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Husband

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/6/1874

8. AGE: Years 72 | Months 10 | Days 11 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William E. Parker
13. Birthplace Maryland

MOTHER 14. Maiden Name Marie Parker
15. Birthplace Maryland

16 (a) Informant Luvina Parker
(b) Address 812 China St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.A.Co. Md

18 (a) Funeral director Josiah L Brandon
(b) Address 108 W Monty ave St

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 11/27/46 19 , at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/5/46 to 11/27/46, and that I last saw h[illegible] alive on 11/27/46.

Immediate cause of death Broncho Pneumonia

Due to Inflammation of the Lungs

Due to Senile Debility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

D. Duration: 10 days

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Lee Ellis M. D.
Address 822 Mad Ave Date 11/29/46

V.S. 150 1540

Every item of information should be carefully supplied. The subject age is especially important. Physicians: please write the causes of death clearly and legibly.

G46037

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 135-B

G46037 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Fla. (b) County
(c) City or town Brooksville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** L. Eugene Lykes, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 9, 1916

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 30 32 | 1, | 20 | hr. min. |

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name F. E. Lykes
13. Birthplace Fla.

MOTHER
14. Maiden Name Meta Roberts
15. Birthplace New York

16 (a) Informant Frederick E. Lykes Jr.
(b) Address Brooksville Fla

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11.30.46 (month) (day) (year)
(c) Cemetery or crematory Lykes
Location Tampa Fla.

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 E. Monument Ave

19 (a) 1946 (Date received by registrar) (b) Registrar

VS 181

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11-29-1946, at 10 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Ruptura of bladder
Peritonitis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-29-46 at 10:40 P. M.
(b) Where did injury occur? Mount Hope Hosp.
(c) Did injury occur at home, on farm, industrial place, in public place? Institution While at work? No
(d) Means of injury Pan into loop guard in knee

23. Signature George B. Merrill M.D.
Medical Examiner.
Date signed 11/30/46

G46038

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46038 Registered No. 83A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 519 S. Caton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 mos

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 S. Caton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Nellie E Trader

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband ~~or wife~~ late Logan J
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28, 1873

8. AGE: Years 73 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name George Keener
13. Birthplace West Virginia

MOTHER
14. Maiden Name Mary E
15. Birthplace West Virginia

16 (a) Informant Mr Sidney Trader
(b) Address 519 S. Caton Ave

17 (a) Removal - Burial (b) Date thereof Dec 2/1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bluemont
Location Grafton, W. Virginia

18 (a) Funeral director Harry N Wyles
(b) Address 701 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/3 1946, to 11/30 1946, and that I last saw h alive on 11/29 1946.

Immediate cause of death Cerebral Hemorrhage — Duration 11/7/46
" " — 2/12/46
Due to General Arteriosclerosis — 2 years
With Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eliot W. Johnson M.D.
Address 3432 Druid Park Ave Date signed 11/30/46

VS 180

G46039

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 E

G46039
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument & Wolfe
(c) Hospital or institution: Union Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Thompson & Belvedere (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Samuel Fisher

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife Not Known
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years 85 | Months | Days | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1-46 (month) (day) (year)
(c) Cemetery or crematory Roosevelt Cem.
Location Phila. Pa.

18 (a) Funeral director Jack Levy Inc
(b) Address 1432 E. Baltimore

19 (a) 12 1 1946 (Date rec'd by registrar) (b) Christopher Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1946, at 1:20 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 11/8 1946 to 11/30 1946 and that I last saw h[im] alive on 11/30 1946

Immediate cause of death: Bronchopneumonia — Duration 8 days

Due to

Due to

Other Conditions Carcinoma Sigma (dx)

(Include pregnancy within 3 months of death)
Date of operation 11-8-46
Major findings of operation:

of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Perelman M. D.
Address Union Hosp Date signed 11/30/46

VS 150

G46040

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46040
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 423 N. Paca St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Monks

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M. | W. | S. |

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) about 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | | | hr. min. |

9. Birthplace Toledo Ohio (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business Clerical Capacity

FATHER
12. Name Robert Monks
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget (Unknown)
15. Birthplace Ireland

16 (a) Informant Zada E. Schramm Fun. Home
(b) Address 987 Superior st. Toledo Ohio

17 (a) Removal (b) Date thereof 12/1/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Toledo
Location Ohio

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (b)
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Nov. 29 1946, at 6 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 27 1946 to Nov. 29 1946, and that I last saw him alive on Nov. 29 1946.

| | Duration |
|---|---|
| Immediate cause of death Respiratory failure | |
| Due to cancer of the lung. | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. M. Leverton M. D.
Address Univ. Hosp. Date signed 11/29/46

VS 150

G46041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G46041
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Monument St. Rutland
(b) Street address Mercy Hosp. Belvedere Av
(c) Hospital or institution: Municipal Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give name)
(d) Street No. 138 N. Wellington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie FRIEDMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Samuel -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1861

8. AGE: Years 85 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Julius -
13. Birthplace Russia

MOTHER
14. Maiden Name Dorothy -
15. Birthplace Russia

16 (a) Informant Harry Friedman
(b) Address 138 N. Wellington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1-46 (month) (day) (year)

(c) Cemetery or crematory United Hebrew
Location Wash. Blvd.

18 (a) Funeral director Jack Levine Inc
(b) Address 1133 E. Baltimore St

19 (a) (Date received by registrar) (b) Registrar

DEC - 1 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1946, at 4:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/25/46 to 11/29 1946, and that I last saw her alive on 11/29 1946.

Immediate cause of death Cerebro-Vasc Accident - Hemiplegia — Duration

Due to Arteriosclerotic cardiovascular disease

Due to

Other Conditions Coronary Thrombosis with Fibrillation
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Boyce L. Brown M. D.
Address Mercy Hosp. Date signed 11/30/46

G46042

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46042 Registered No. 93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2476 Shirley Ave
(c) Hospital or institution: Mt. Carmel Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2239 N. Pulaski St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Rose Solomon

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Andrew

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | | | 18hr 81 min. |

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER
12. Name Yankov
13. Birthplace Poland

MOTHER
14. Maiden Name Goldie
15. Birthplace Poland

16 (a) Informant Gilbert Solomon
(b) Address 3331 Alto Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phil Rd + Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto. St

19 (a) (Date rec'd by Registrar) (b) Livingston Williams, Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11-30-46 19 , at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1939 to Nov. 30 1946, and that I last saw h[illegible] alive on Nov. 29 19 46

Immediate cause of death Congestive Heart Failure — Duration 4 mo

Due to Arteriosclerotic Ht. Disease — 7 yrs

Due to — 7 yrs

Other Conditions Coronary artery Disease! —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. M. S. Shelley M. D.
Address 2426 Eutaw Pl. Date signed 11/30/46

VS 150

G46043

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

G46043
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 11
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2532 Park Heights Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Bessie Laff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Judah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 78 | Months | Days | If less than one day 1868 min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Herman Laff
(b) Address 4033 Bonner Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd + Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1479 E Balto St

19 (a) DEC 1 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11/29 1946 at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/29 1946 to 11/29 1946 and that I last saw her alive on 11/29 1946

Immediate cause of death Respiratory failure — Duration

Due to Pulmonary edema

Due to AS + HHD, decompensated

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sidney Green M. D.
Address Sinai Hospital Date signed 11/29

VS 150

G46044

499039.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

157 A

G46044
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State N.C. (b) County
(c) City or town Washington N.C.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706 21st St. N.E.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Robert E. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Black | |

6 (b) Name of husband or wife 11-20-44

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-20-[illegible]

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 2 | | 9 | hr. min. |

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert P Smith
13. Birthplace N.C.

MOTHER
14. Maiden Name Mamie Reand
15. Birthplace N.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof [illegible] 4 14 46
(month) (day) (year)

(c) Cemetery or crematory
Location Washington D.C.

18 (a) Funeral director Ellwood Fairchilds
(b) Address 1432 Good St. N.E.

19 (a) [illegible] (b) Washington D.C.
(Date rec'd by registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Nov. 29 1946 at 8.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1946 to Nov. 29 1946 and that I last saw him alive on Nov. 29 1946.

| Immediate cause of death | Duration |
|---|---|
| Postoperative Convulsions + hyperthermia | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation 29 Nov 1946

Major findings of operation: Hydrocephalus

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles W. Burton M. D.
Address Johns Hopkins Hosp. Date signed 30 Nov 46

VS 150

G46045

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓131A

Registered No. G46045

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1329 Smithson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1329 Smithson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Elizabeth Williams Pettyman.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | Widow |

6 (b) Name of husband or wife Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 16, 1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | | 12 | hr. min. |

9. Birthplace Crowdensville, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Charles Williams.
13. Birthplace Md.

MOTHER
14. Maiden Name Harriett Johnson
15. Birthplace Md.

16 (a) Informant Harriett Nichols
(b) Address 1060 Vine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 1 1946 (month) (day) (year)

(c) Cemetery or crematory Western Star Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) 1 1946 (Date received by registrar) (b)

Registrar Huntington Williams, M.D.

V S 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 11/28/1946, at 7 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 1946 to 11/28 1946
and that I last saw he alive on 11/27 1946

| Immediate cause of death | Duration |
|---|---|
| Acute Cardiac Vascular Renal Disease. | 7 yr. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.

Address 600 N Glenwood Ave Apt 4 11/30/46

G46046

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 73D

G46046
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 31st + Wyman Park Dr.
(c) Hospital or institution: U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 d
(e) Length of stay in Baltimore (yrs., mos., or days) 11 mons

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Pa (b) County
(c) City or town Crabtree (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 197 - Main St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] (Valerio Dibeardini

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 / 20 / 26

8. AGE: Years 20 | Months 1 | Days 10 | If less than one day — hr. — min.

9. Birthplace Crabtree, Pa. (town, county, and state)
10. Usual Occupation Writer
11. Industry or business Merchant Marine

FATHER
12. Name Carmen Beardini
13. Birthplace Italy

MOTHER
14. Maiden Name adeline ?
15. Birthplace Pennsylvania

16 (a) Informant Hospital Records
(b) Address 31st + Wyman Park Dr

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 4-1946 (month) (day) (year)
(c) Cemetery or crematory Calvary Hill
Location Crabtree Pa.

18 (a) Funeral director Ellsworth Ammerman
(b) Address 3911 Liberty Heights Ave

19 (a) — (b) Huntington, West Virginia
(Date received by registrar) DEC 1 1946

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 11-30- 1946, at 6:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1946 to Nov 30 1946 and that I last saw h[illegible] alive on Nov 30 1946

Immediate cause of death Aplastic anemia — Duration 40 days
Due to cause unknown
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles D. Spickmall
Address U.S. Marine Hosp Date signed 11-30-46 (M.D.)

X

G46047

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1936

G46047
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution:
Church Home & Hosp. (Home)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 mon
(e) Length of stay in Baltimore (yrs., mos., or days) 11 mon

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Calvert
(c) City or town Broomes Island
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

**3 (a) FULL NAME** Lucinda Hodges

3 (b) If veteran, name war —

3 (c) Social Security Account No. — —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| femal | white | widowed |

6 (b) Name of husband or wife Ramsey Hodges
6 (c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) Sept 3 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 2 | 29 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business —

FATHER
12. Name Thomas A Duckett
13. Birthplace Maryland

MOTHER
14. Maiden Name Lucinda Sellman
15. Birthplace Maryland

16 (a) Informant Lucinda Hodges
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 3 1946 (month) (day) (year)
(c) Cemetery or crematory Davidsonville
Location Davidsonville, Md.
18 (a) Funeral director E. N. Lansdale
(b) Address 4570 Liberty Hgts Ave
FC (a) 12-1 1946 (Date rec'd by Registrar) (Huntington Williams M.D.)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-1- 1946, at 6:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 11 1946 to Dec 1 1946 and that I last saw her alive on Nov 30 1946.

Immediate cause of death Infarction of myocardium due to arteriosclerotic coronary thrombosis — Duration 10 days
Due to arteria sclerotic heart disease — 20 years
Due to —
Other Conditions hypertensive cardiovascular disease
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dorance S Ensberg M.D.
M. D.
Address Church Home & Hosp. Date signed 12-1-46

VS 150

G46048

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1469

G46048 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 117 E. 25th St.
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County ----------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 E. 25th. St.
(If rural give location)
(e) Citizen of foreign country? ---------- (Yes or No)
If yes, name country ----------

**3 (a) FULL NAME** Anne H. Winchester

3 (b) If veteran, name war ----------
3 (c) Social Security Account No. ----------

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife ----------
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) 4/1/1869

8. AGE: Years 77 | Months 7 | Days 28 | If less than one day --- hr. --- min.

9. Birthplace New Jersey (Town, county, and state)
10. Usual Occupation None
11. Industry or business ----------

FATHER
12. Name George H. Winchester
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Maria Parkinson
15. Birthplace Portland, Maine

16 (a) Informant Mrs. Walter Wells
(b) Address 117 E. 25th. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/46 (month) (day) (year)
(c) Cemetery ####### Green Mount
Location Baltimore, Md.

18 (a) Funeral director H. H. Mears & Son
(b) Address 805 N. Calvert St.

19 (a) DEC - 1 1946 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29th 1946, at 7:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20th 1946 to Nov. 29th 1946, and that I last saw h-- alive on Nov. 28th 1946

Immediate cause of death: Carcinoma of Pancreas with widespread metastases — Duration: 3 months?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Conrad Wolf
Address 11 E. Chase St. Baltimore 2, Md. X
Date signed 11/30/46 M. D.

G46049

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94A

G46049 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Ingram Hall Apts. 7301 Park Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 302 Ingram Hall Apts.-7301 Park Heights Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** LEE S. MEYER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Hortense H. Meyer
6 (c) If alive, give age: 76 years
7. Birth date of deceased (mo., day, yr.) June (21), (1877) 1876
8. AGE: Years 70 (69) Months 5 Days 3 (8) If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business Self

FATHER
12. Name Michael Meyer
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Bertha Stern
15. Birthplace Germany

16 (a) Informant Mr. Stewart Hecht, Brother-in-Law
(b) Address Balto. & Pine Sts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/46 (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

17 (c) [illegible] (Date received by registrar) (b) Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 to Nov 29 1946, and that I last saw h[illegible] alive on Nov 28 1946.

Immediate cause of death: Aortic valve failure — Duration: 2 years
Due to: coronary thrombosis — Duration: 1 year
Due to: — Duration:
Other Conditions: — Duration:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address [illegible] Date signed 12/30/46

V S 150

G46050 G46050

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1930

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3827 Barrington Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3827 Barrington Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Virginia L. Shay

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife George T. Shay
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2 1862

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 84 | 3 | 28 | hr. min. |

9. Birthplace Snow Hill Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Dr. Edwin S. Dickerson
13. Birthplace Maryland

MOTHER
14. Maiden Name Virginia Tingle
15. Birthplace Maryland

16 (a) Informant Grace T. Shay
(b) Address 3827 Barrington Road

17 (a) Burial (b) Date thereof Dec 2 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Henry Thuraco
(b) Address 4204 Ridgewood Ave

19 (a) DEC 1 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30 1946, at 8:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 21 1946, to Nov 30 1946, and that I last saw h[illegible] alive on Nov 29 1946.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Embolism | Sudden |
| Due to Cardio Vascular Disease | 25 yr. |
| Due to Arteriosclerosis | 4 Years |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph N. Zuerlein M. D.
Address 6318 Eastern Ave Date signed 12/1/46

X

G46051

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 470

G46051
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3804 9th St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore 15 (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3804 9th Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert R George

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Reaven George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5 1891

8. AGE: Years 55 Months 7 Days 25 If less than one day hr. min.

9. Birthplace New Haven Conn. (Town, county, and state)

10. Usual Occupation Steamfitter

11. Industry or business Pipe & Steamfitting Union

FATHER 12. Name Frank George

13. Birthplace Conn.

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Clarence E. George

(b) Address 4210 Curtis ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/46. (month) (day) (year)

(c) Cemetery or crematory Glen Haven Cem

Location Glenburnie Md.

18 (a) Funeral director Milton Schuler

(b) Address 3914 Hanover St

19 (a) 1 1946 (Date filed by Registrar) (b) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11/30 1946 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/18 1946 to 11/30 1946, and that I last saw him alive on 11/30 1946.

| | Duration |
|---|---|
| Immediate cause of death Carcinoma 1 lung with 2 metastases. | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation April 26 46

Major findings of operation: Carcinoma of lung

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James R. Evans M. D.

Address 3012 Petyjean St. Date signed 11/30/46

Rosen

G46052

BALTIMORE CITY HEALTH DEPARTMENT

G46052 Registered No.

# CERTIFICATE OF DEATH 1936

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Green Spring + Belvedere Ave
(c) Hospital or institution Kendall
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2227 E. Balto St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pinkus Rosen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years 87 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Ret

11. Industry or business

FATHER
12. Name Wolfe
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael
15. Birthplace Russia

16 (a) Informant Mrs. Lena Davis
(b) Address 534 N Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1-46 (month) (day) (year)
(c) Cemetery or crematory Mt Lebanon Location Glenmont Ave

18 (a) Funeral director Jacob Levine Inc
(b) Address 1439 E. Balto St

19 (a) 12-1-1946 (Date received by registrar) (b)

Registrar Washington Williams Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 1 1946, at 5:17 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-31 1935 to 12-1 1946, and that I last saw h[illegible] alive on 12-1 1946

| Immediate cause of death | Duration |
|---|---|
| Acute coronary | |
| Thr. card. vas. disease | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr Edmund Rosen

Address Reisterstown Date signed 12/2/46

VS 150

X

G46053

G46053

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 121

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave.
(c) Hospital or institution: Church Home & Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town Dundalk, 22
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6591 St. Helena Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Guscott

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Not known from the Informant

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 8 | 11 | hr. min. |

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Retired railroader

11. Industry or business

FATHER
12. Name Eli Guscott
13. Birthplace England

MOTHER
14. Maiden Name Eliz. Jane (Guscott)
15. Birthplace England

16 (a) Informant Admission Sheet
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 1-46 (month) (day) (year)
(c) Cemetery or crematory Longnecker Mem.
Location Longnecker Pa.

18 (a) Funeral director John G. Miller
(b) Address 2334 Jefferson St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

DEC 1 1946

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 1 1946, at 5:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29 1946, to Dec. 1 1946, and that I last saw him alive on Dec. 1, 1946.

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure | terminal |
| Due to Peritonitis | 4-5 days |
| Due to Ruptured Appendix | 5 days |
| Other Conditions Old age. | |

(Include pregnancy within 3 months of death)

Date of operation Nov. 30, 1946.
Major findings of operation: Ruptured Appendix - Gangrene
of autopsy: Not obtained.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wayne N. Jacobus, M.D.
M. D.
Address Church Home & Hospital Date signed Dec. 1, 1946

X

G46054

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 467

G46054 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 805 N. Kenwood Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 805 N. Kenwood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** JOHN GEORGE WALZ

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| male | white | married |

6 (b) Name of [redacted] or wife Albina (nee Zelenka)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 13, 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 yrs. | 3 | 15 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Maritime Commission

FATHER
12. Name John Walz
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Albina F. Hall - daughter
(b) Address 3508 Lyndale Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/46 (month) (day) (year)
(c) Cemetery or [redacted] Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) Dec 1 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH November 26 1946 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1946 to Nov 26 1946 and that I last saw him alive on Aug 28 1946.

Immediate cause of death Acute Cardiac Dilatation — Duration 11/26/46

Due to Chronic Myocarditis — 8-1-46

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Rhoads M.D.
Address 801 N Kenwood Ave Date signed 11/26/46

VS 150

G46055

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 471

G46055 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2736 Tivoly Avenue
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2736 Tivoly Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** WILLIAM MAPP BUNTING

3 (b) If veteran, name war: no.
3 (c) Social Security Account No. 216-09-1491

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Dora (nee Becker)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13 1896

8. AGE: Years 60 | Months 8 | Days 16 | If less than one day hr. min.

9. Birthplace Quinby, Virginia. (Town, county, and state)
10. Usual Occupation Manager
11. Industry or business Acme Stores

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Ernest Bunting - son
(b) Address 2736 Tivoly Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Taylor Ave. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison St.

19 (a) (Date rec'd by registrar) DEC - 1 1946 (b) Registrar Huntington Williams M.D.

VS-750

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 11/29/46 19 at 6a M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1- 1946 to 11-25 1946, and that I last saw h[illegible] alive on 11-25 1946

| Immediate cause of death | Duration |
|---|---|
| acute pulmonary oedema | 6 min. |
| Due to Carcinoma of Lung. | |
| Due to Intestinal. | 2 Months |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 11-18-46
Major findings of operation: Annular Carcinoma of Trachea, proven by Biopsy
of autopsy:

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Egbert L. Mortimer Jr M. D.
Address 2206 St Paul St Date signed 11/30/46

No age on Trailer

G46056

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

G46056 Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address 1400 N Caroline St

(c) Hospital or institution St Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2231 Guilford Ave

(If rural give location)

(e) Citizen of foreign country? — (Yes or No)

If yes, name country

3 (a) **FULL NAME** Agnes Toal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 74 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER 12. Name John Toal

13. Birthplace Ireland

MOTHER 14. Maiden Name Elizabeth O'Neill

15. Birthplace Ireland

16 (a) Informant Mrs Michael O'Meara

(b) Address 2231 Guilford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-1946 (month) (day) (year)

(c) Cemetery or crematory Cathedral Cemetery

Location

18 (a) Funeral director Mary M. Wiedefeld

(b) Address 50 E. 22nd St

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11/28 1946, at 1:40 P M

21. I certify that death occurred on the date above stated that I attended deceased from 11/12 1946 to 11/28 1946 and that I last saw her alive on 11/28 1946.

| Immediate cause of death | Duration |
|---|---|
| (a) Cardiac Failure | |
| Due to (b) Hypertensive Arteriosclerotic | |
| Due to (c) Cardio Vas. Disease | |
| Other Conditions Duodenal Ulcer. | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Huntington Williams M.D.

Address St Joseph Hospital Date signed 11/28/46

VS 150

2. Prom Supt G46057

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94A

G46057. Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore # 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 E. 20th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William A. Reinhardt, Jr

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business Butcher Business

FATHER
12. Name William C. Reinhardt
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Sara Dilberg
15. Birthplace Baltimore Md

16 (a) Informant Mrs Sara Reinhardt
(b) Address 1123 E. 20th St

17 (a) Burial (b) Date thereof 12 - 2 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem
Location Loetus Redfield

18 (a) Funeral director
(b) Address 507 E. 22nd St

19 (a) Date filed by registrar 1946 (b) Huntington Williams, Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 11-28 19 46 at 9.21 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from 11-28 19 46 to 11-28 19 46 and that I last saw h. in alive on 11-28 19 46

| Immediate cause of death | Duration |
|---|---|
| Cardio respiratory failure | |
| Due to Coronary Occlusion | |
| Due to Coronary Arteriosclerosis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23.** Signature
Address 1 St Joseph Place Date signed 12/3/46

VS 150

G46058

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

G46058 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1923 W. Franklin St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1923 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** HARRY E. BREMKER

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 213-12-8687

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Phebe Bremker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 25, 1874

8. AGE: Years: 72 | Months: 7 | Days: 2 | If less than one day: hr. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: Mrs. Charlotte Crowther
(b) Address: 2139 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)
DEC 1 1946

## MEDICAL CERTIFICATION

P

20. DATE OF DEATH Nov. 27, 1946, at 9:27 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1946, to Nov 27 1946, and that I last saw h[illegible] alive on Nov. 26 1946

Immediate cause of death: Arteriosclerotic Cardio Vascular Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: [illegible]

Address 400 N. Payson St. Date signed 11/29/46 M.D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46059

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

G46059 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4403 Fernhill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 4403 Fernhill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** CLARA A. HIBLINE

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 0 | 11 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Men's Hats, Inc.

FATHER
12. Name George Hibline
13. Birthplace Saxe-Coburg

MOTHER
14. Maiden Name Agnes Grandlemeyer
15. Birthplace Switzerland

16 (a) Informant Mr. G. Alan Sheain
(b) Address 4403 Fernhill Ave. 15

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11-29 1946 at 3-30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1946 to Nov 29 1946 and that I last saw h[illegible] alive on Nov 29 1946.

| Immediate cause of death | Duration |
|---|---|
| Bronchial Pneumonia | 2 days |
| Due to Carcinoma of Brst | 1 yr |
| Due to age | |
| Other Conditions age | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. L. Kuyer M. D.
Address Wadsworth Apts Date signed 11-29-46

Dr Darby 2 11 G46061 D RD. 2 T.F.

BALTIMORE CITY HEALTH DEPARTMENT X G46061D
Registered No.

# CERTIFICATE OF DEATH V131a

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2900 Southern Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Pa (b) County
(c) City or town Marysville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

**3 (a) FULL NAME** Cora M. Hess

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F. | W. | widowed |

6 (b) Name of husband or wife Simon E. Hess
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 11 | 24 | hr. min. |

9. Birthplace Penna.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Hipple
13. Birthplace Penna

MOTHER
14. Maiden Name Mary J. Fried
15. Birthplace Penna

16 (a) Informant Theo. E. Hess.
(b) Address 2900 Southern Ave.

17 (a) Removal (b) Date thereof 12 1 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Chestnut Grove.
Location Marysville, Penna.

18 (a) Funeral director William Cobb Inc.
(b) Address 217 N. Paul st.

19 (a) DEC 1946 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Dec 1 1946, at 9 30 A.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from Nov 26 1946 to Dec 1 1946, and that I last saw h[er] alive on Dec 1 1946

Immediate cause of death: Cardiac Dilatation — Duration: Between attack and death

Due to: Chronic Interstitial Nephritis

Due to:

Other Conditions: Hypertension Congestive Failure — 1 day

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. A. Darby M.D.
Address 817 Medical Arts Bldg Date signed Dec 2 1946

G46067 BALTIMORE CITY HEALTH DEPARTMENT G46067

# CERTIFICATE OF DEATH

Registered No. 546 546061

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CAROLINE St.
(c) Hospital or institution: ST JOSEPHS HOSPITAL.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 18 da

2. USUAL RESIDENCE OF DECEASED:
(a) State VA (b) County
(c) City or town MARTINSBURG (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME NUNZIO QUALINI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife Cinderella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-25-81

8. AGE: Years 65 | Months 8 | Days 6 | If less than one day hr. min.

9. Birthplace ITALY. (Town, county, and state)

10. Usual Occupation CEMENT PLANT

11. Industry or business

FATHER 12. Name Qualini
13. Birthplace Italy

MOTHER 14. Maiden Name Mary
15. Birthplace Italy

16 (a) Informant Grace Mary Qualini
(b) Address Martinsburg W. Va

17 (a) Burial (b) Date thereof 12 1 46 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Josephs Cemetery
Location Martinsburg W. Va.

18 (a) Funeral director Williams Cook Inc.
(b) Address 1217 St Paul st. Balto Md

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 1 1946, at 1 05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-12 1946, to 12-1 1946, and that I last saw him alive on 12-1 1946.

Immediate cause of death CARDIO RESPIRATORY FAILURE — Duration
Due to GENERAL METASTASIS /
Due to CARCINOMA OF LIVER MULTIPLE
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 11-23-46
Major findings of operation: CARCINOMA LIVER
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John B. Wells M. D.
Address St Jos Hosp Balto Date signed 12-14-46

EG-1 VS 15 1946 Huntington Williams, M.D.

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# HEALTH DEPARTMENT—CITY OF BALTIMORE

G46062

G46062

CERTIFICATE OF DEATH 131a

1. PLACE OF DEATH

Registered No.

CITY OF BALTIMORE: (No. 2117 Denison St. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME SARAH SANFORD

(a) Residence: No. 1626 24th St Washington D.C. Ward.
(Usual place of abode) (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. Color or Race | 5. Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| female | white | widow |

6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) July 9-1865

| 7. AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 81 | | | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Housewife

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Washington D. C.

FATHER

13. NAME ? Brightwell

14. BIRTHPLACE (city or town) (State or country) Washington, D.C.

MOTHER

15. MAIDEN NAME Dont Know

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT John Koenig

(Address) Washington D. C.

18. BURIAL, CREMATION, OR REMOVAL

Place Cedar Hill Wash DC Date Dec 4 1946

19. UNDERTAKER Murray Lynch Home

(Address) 2007 Nichols Ave S.E. Wash DC

20. DEC 2 1946 Huntington Williams, Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) DEC 1, 1946

22. I HEREBY CERTIFY, That I attended deceased from Nov 29, 1946 to DEC 1, 1946

I last saw h[illegible] alive on NOV 30, 1946 Death is said to have occurred on the date stated above, at 1 P. m.

The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Respiratory failure | |
| Due To: Cerebral thrombosis | |
| Due To: Arteriosclerotic Cardio-vascular renal disease | |

Other contributory causes of importance:

Was an operation performed? No Date of

For what disease or injury?

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) I. Shorofsky M.D. M. D.

(Address) 601 N. Monroe St.

OCCUPATION is very important. See instructions on back of certificate.

G-46063

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered 46063

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2439 Edmonston Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town (If outside city or town, write RURAL and name town)
(d) Street No. 2439 Edmonston Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Everett E Holland

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Sallie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 16 1862

8. AGE: Years 83 64 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Stock keeper Retired

11. Industry or business

FATHER
12. Name Thomas Holland
13. Birthplace Md

MOTHER
14. Maiden Name Susan Eggleston
15. Birthplace Md

16 (a) Informant Bernice H Lynch
(b) Address 2439 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/46 (month) (day) (year)

(c) Cemetery or crematory East Nat'l Market
Location East Nat'l Market Md

18 (a) Funeral director Myhorn & Son Inc
(b) Address 2147 E Pont St

19 (a) DEC - 2 1946 (Date rec'd by registrar) (b) Registrar, Baltimore, Md.

VS 151

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec 1 1946, at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy & Inq thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute pulmonary Edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William Skelbick M.D. (Medical Examiner)
Date signed Dec 1 - 1946

G46065 4

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

Registered No. G46064

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lexington St
(c) Hospital or institution: 4th
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2328 E. Hoffman St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary E. Draver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Edward L. Draver

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 13th 1875

8. AGE: Years 71 | Months 0 | Days 7 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert A. Sanford
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs T. M. Harvey
(b) Address 5577 Ashbourne Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director William Cook Inc.
(b) Address 247 St. Paul St

19 (a) DEC 2 1946 (b) Hunting for Williams M.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Nov 30th 1946, at 1 P. M 45

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to Nov 30 1946
and that I last saw h[illegible] alive on Nov 30 1946

Immediate cause of death: General arterio sclerosis
Due to: Myocarditis
Due to: Diabetes mellitus

Duration: 10 yrs

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
Autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert J. Solomon
Address 129 E Biddle Date signed 11/30/46

VS 150

G46065

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 1310

Registered No. G46065

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 806 W. University Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 W. University Pkwy (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Burnet Wright

3 (b) If veteran, name war: Wrld War I
3 (c) Social Security Account No. NONE

4. Sex: Male
5. Color or race: White
6 (a) ~~Single~~, married, ~~widowed~~ or ~~divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Alta Gauthier Wright

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 2nd 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 1 | 28 | hr. min. |

9. Birthplace Boston Mass
(Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business Own Business

FATHER
12. Name Rev Wm B. Wright
13. Birthplace Ohio

MOTHER
14. Maiden Name Lucretia Johnson
15. Birthplace Mass

16 (a) Informant Mrs Alta C. Wright
(b) Address 806 University Pkwy

17 (a) Burial (b) Date thereof 12/3/46
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc
(b) Address 217 St Paul St

19 (a) (b)
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30 1946, at 6 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946, to Nov 30 1946, and that I last saw ~~him~~ alive on Nov 29 1946

| Immediate cause of death | Duration |
|---|---|
| Intracranial hemorrhage | |
| Due to Cardio vascular renal disease | |
| Due to | |
| Other Conditions Senility. | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter H Grauten M. D.
Address 4209 Hamilton Date signed 11/30/46

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46066 / 94a

Registered No. G46066

G46066

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St Josephs Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4420 Furley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. John E. Reinhardt

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-2881

| 4. Sex | 5. Color or race | 6 (a) Single, married, ~~widowed, or divorced~~ |
|---|---|---|
| Male | White | Married |

6 (b) Name of ~~husband or~~ wife Mary M. Reinhardt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29th 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 2 | 0 | hr. min. |

9. Birthplace St. Paul Minn.
(Town, county, and state)
10. Usual Occupation Sheet Metal Worker
11. Industry or business W. A. Fuglers Co

FATHER
12. Name John E. Reinhardt
13. Birthplace St. Paul Minn.

MOTHER
14. Maiden Name Minnie Hoenschmidt
15. Birthplace Germany

16 (a) Informant Mrs. Mary M. Reinhardt
(b) Address 4420 Furley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/46 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md

18 (a) Funeral director Watson & Son
(b) Address 1217 E. Pratt St

19 (a) DEC - 2 1946 (b)
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 1946, at 745 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 28 1946 to Nov 29 1946 and that I last saw h.s.M. alive on Nov 29 1946.

| Immediate cause of death | Duration |
|---|---|
| Cardio-respiratory failure | |
| Due to Coronary arterio-sclerosis | |
| Due to | |
| Other Conditions Pulmonary Congestion, Bilateral (Include pregnancy within 3 months of death) | |

Date of operation none
Major findings of operation:
of autopsy: occlusion of Common iliac arteries, Bilateral

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address [illegible] Date signed 12/4/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

G16067 **CERTIFICATE OF DEATH** √131a Registered No. G16067

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1912 N Wolfe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1912 N Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lillian C Hughes

3 (b) If veteran, name war None | 3 (c) Social Security Account No. None

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Oliver C
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 20 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 2 | 10 | hr. min. |

9. Birthplace York Pa (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

| | |
|---|---|
| FATHER 12. Name | Henry A Herbst |
| 13. Birthplace | Pa |
| MOTHER 14. Maiden Name | Libba J Mugel |
| 15. Birthplace | Pa |

16 (a) Informant Clarence Dameron
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/46 (month) (day) (year)
(c) Cemetery or crematory Union
Location Glen Rock Pa

18 (a) Funeral director Fullerton & Son
(b) Address 1211 N Gay St

19 (a) DEC - 2 1946 (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Nov 30 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21, 1946 to Nov. 30 1946; and that I last saw h alive on 19

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 8 days |
| Due to Hypertensive Cardio-vascular Renal Disease | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel D Wolfe M. D.
Address 1331 S Hostler Date signed 12-3-46

VS 150

FORMS WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

46068

BALTIMORE CITY HEALTH DEPARTMENT

AB-106380

# CERTIFICATE OF DEATH

Registered No. G46068

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1845 Andre St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Frederick) Fred Cornell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife: Helen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8- 1886

8. AGE: Years 60 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Arthur (D
13. Birthplace Belgium

MOTHER
14. Maiden Name Mary (D
15. Birthplace Belgium

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 12-2-46 (month) (day) (year)
(c) Cemetery or crematory Frederick Burial Location Frederick, Md.

18 (a) Funeral director James L. McCauley
(b) Address 108 S. Front St.

19 (a) (Registrar) (b) Huntington Williams, M.D.

DEC 2 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 19 46, at 4.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-25- 19 46 to 11-29 19 46, and that I last saw h im alive on 11-29 19 46

Immediate cause of death Bronchopneumonia, Organism unknown — Duration

Due to

Due to

Other Conditions (1) Arteriosclerosis (2) Cerebral Thrombosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin C. Evans M. D.

Address Balto. City Hospitals Date signed 11-29-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46069

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

G46069 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2116 Barclay Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2116 Barclay Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Scott Stansbury

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Columbia Elizabeth Stansbury

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 31-1864

8. AGE: Years 82 Months 9 Days 29 If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Policeman

11. Industry or business Retired 9 years

FATHER
12. Name John Stansbury
13. Birthplace England

MOTHER
14. Maiden Name Sarah Carter
15. Birthplace England

16 (a) Informant Mrs. Harry B. Hopps
(b) Address 2116 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 2-1946 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 321 Falls Road

19 (a) DEC - 2 1946 (Date rec'd by registrar) (b) Huntington W. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29- 1946 at 1.35 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 25 1946 to Nov 29 1946; that I last saw h alive on Nov 25 1946

| Immediate cause of death | Duration |
|---|---|
| (a) Uremia & Hypostatic Pneumonia | 2 days |
| Due to Arteriosclerosis | 3 yrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. D. Thurston M. D.
Address 2136 Maryland Ave Date signed Nov 29 1946

VS 150

IMPORTANT—WRITE LEGIBLY, WITH UNFADING INK. Every item must be answered; every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46070

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 462

Registered No. G46070

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1363 N. Stricker St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1363 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? Yes. (Yes or No) If yes, name country

**3 (a) FULL NAME** Eliza Frances Dorsey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: John H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1894

8. AGE: Years 52 | Months 8 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Alex Cooper

13. Birthplace St. Mary's Co. Md.

MOTHER 14. Maiden Name Lydia Posey

15. Birthplace St. Mary's Co. Md.

16 (a) Informant Dorothy M. Davis

(b) Address 1363 N. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 5-1946 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore, Md.

18 (a) Funeral director Mrs. Lucy N. Sullivan

(b) Address 1651 Druid Hill Ave.

19 (a) ____ (Date received by registrar) (b) Huntington Williams, M.D. Registrar

DEC 2 1946

V S 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Nov 28 1946 Dar 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-17 1946 to 11-28 1946 and that I last saw h[illegible] alive on 11-28 1946.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma Stomach | 6 mo |
| Due to | 16 d |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Williams M.D.

Address 1 W. Pa Ave Date signed 11/30/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46071

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 178C

Registered No. G46071

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3rd floor-rear- 1206 W. Fayette (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** JOSEPH MANN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct-19-1902

8. AGE: Years 44 yrs | Months 1 | Days 10 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business B & O R R

FATHER
12. Name B. F. Mann
13. Birthplace Virginia

MOTHER
14. Maiden Name Jane B. Davis
15. Birthplace Virginia

16 (a) Informant Mrs Pearl Ralf
(b) Address Route #7 Box 96 Rich. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-46 (month) (day) (year)

(c) Cemetery or crematory
Location Richmond Virginia

18 (a) Funeral director John E. Miller Jr.
(b) Address 2435 E. Oliver St.

19 (a) (Date received by registrar) (b) Huntington Williams Registrar

DEC 2 1946

VS-151

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Nov. 29, 1946, at 9.25 a M

**21.** I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Carbon Monoxide

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 18-2

(a) Date of injury 11-29-46 at 9 a.m.
(b) Where did injury occur? 3rd floor-rear- 1206 W. Fayette St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Fumes from burning mattress

23. Signature Howard J. Mearns M.D.
Medical Examiner.

Date signed 11-29-46

X

G46072

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 123

R G46072

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 733 W. Mulberry St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 733 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN H. DUCKETT

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-4629

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1886

8. AGE: Years 60 | Months 5 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name George T. Duckett
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Lane
15. Birthplace Md.

16 (a) Informant George F. Duckett
(b) Address 733 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC - 2 1946

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29, 1946, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/7/46 to 11/29/46, and that I last saw h alive on 11/29/46

Immediate cause of death Uremia Poisoning — Duration 4 days

Due to Convulsions

Due to Broncho pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Lane Uhlig M. D.

Address [illegible] Date signed 12/2/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46073

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registration No. G46073

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1224 N. Broadway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Brayden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Lola E. Brayden

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1882

8. AGE: Years 64 | Months 7 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Retired - Night Watchman

11. Industry or business Sinai Hospital

FATHER
12. Name Samuel Brayden
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret Durkin
15. Birthplace Tipp, Md.

16 (a) Informant Lola E. Brayden
(b) Address 1224 N. Broadway

17 (a) Burial (b) Date thereof Dec. 4 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 N. Paul St.

19 (a) (b) Tunstall Williams, M.D.
(Signature of local registrar) Registrar

DEC 2 1946

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 1, 1946, at 12 25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 16 July 1946 to 1 Dec 1946, and that I last saw h[illegible] alive on 1 Dec 1946.

| Immediate cause of death | Duration |
|---|---|
| Coronary insufficiency | ? |
| Due to Arteriosclerosis | ? |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Silverfer, M. D.
Address 714 E. Preston Date signed 2 Dec 46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46074

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

G46074

Registered No.

Please write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write the

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1413 Patterson Pk. Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 Patterson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Arthur J. Wonderly

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M. | W | D |

6 (b) Name of husband or wife Ida L. Zepp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1860

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 86 | 4 | 1 | hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant Raymond S. Wonderly
(b) Address 1413 Patterson Pk Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) [illegible] (b) [illegible] Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1946, at 6:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 11 1946 to Nov. 28 1946, and that I last saw h alive on Nov. 25 1946

Immediate cause of death Arteriosclerosis, generalized — Duration unknown

Due to

Due to

Other Conditions Arteriosclerotic Heart Disease — unknown
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edgar Stuess M. D.
Address 6232 Belair Road Date signed Nov. 29, 1946

VS 150

G46075

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1864 G46075 File No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 N. Decker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs John H. Hoofnere

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1860

8. AGE: Years 86 | Months 7 | Days 24 | If less than one day hrs. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant David Hoofnere
(b) Address 12 N. Decker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director C. F. Hoffmann. Clarence F. Hoffmann
(b) Address 1639 Broadway

19 (a) (Date rec'd by registrar) DEC 2 1946 (b) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Nov 28 1946 at 6:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 24 1946 to Nov 28 1946 and that I last saw him alive on Nov 27 1946

Immediate cause of death: Cardio-respiratory Failure — Duration

Due to Bilateral Lobar Pneumonia

Due to Tuberculosis, Pulmonary apex

Other Conditions Fracture Left Femur

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: Intra-vital Removal

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Nov 23 at 9:30 P M
(c) Where did injury occur? Baltimore (City or town) Baltimore (County) Md (State)
(d) Did injury occur about home, on farm, industrial place, in public place? About home While at work? No (Specify home, farm, industrial place, etc.)
(e) Means of injury Fall down stairs — Cerebral Hemorrhage

23. Signature Henry P. Janke

Address St Joseph's Hosp Date signed 11/28 M. D.

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Penitentiary supplies.

Huntington Williams, M.D.

Approved by Cd Tuberculosis

G46076

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1930

Registered No. G46076

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2904 RIDGEWOOD AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1
(e) Length of stay in Baltimore (yrs., mos., or days) 28 YRS

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1646 E. PRATT ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HANNAH PORTNOI

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEMALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife SAMUEL

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name MICHEL
13. Birthplace RUSSIA

MOTHER
14. Maiden Name MOLKA
15. Birthplace RUSSIA

16 (a) Informant HUSBAND
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pulaski Hy & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

19 (a) DEC 2 1946 (Date filed by registrar) Registrar

Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/1/1946, at 4P M

21. I certify that death occurred on the date above stated; that I attended deceased from DEC 1ST 1946, to DEC 1ST 1946, and that I last saw her alive on DEC 1ST 1946.

| Immediate cause of death | Duration |
|---|---|
| Hypertensive Cardiovascular Disease | 2-3 yrs |
| Due to Cerebral Hemorrhage | 1 hour |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alan A Weinstock M. D.

Address 4603 Park Heights Ave Date signed 12/1/46

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G46077

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

Registered No. G46077

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1634 Linton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Gold

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife Hyman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Philip
13. Birthplace Russia

MOTHER 14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-46 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Druid Hill Rd

18 (a) Funeral director Jack Lamm Inc
(b) Address 1439 E. Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2 1946, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 11 1946, to Dec 2 1946, and that I last saw her alive on Dec 2 1946

Immediate cause of death Myocardial Failure — Duration

Due to Arteriosclerotic hypertensive cardio-vascular disease

Due to

Other Conditions Pulmonary infarction

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Royce L Brown M.D.
Address Sinai Hospital Date signed 12/7/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G46078

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

137 A Registration No. G46078

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument H
(c) Hospital or institution: Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42yo

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2818 Boarman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Jacob Zuckerberg~~ JACOB ZUKERBERG

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife Sarah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER 12. Name Samuel
13. Birthplace Russia
MOTHER 14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-46 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Monument Hill Rd.
18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Dec 1946 at 6:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/17/46 19 to 12/1/46 19, and that I last saw him alive on 12/1/46 19.

| | Duration |
|---|---|
| Immediate cause of death Shock | |
| Due to Cardiac Failure | 36 hrs |
| Due to Coronary Occlusion | 36 hrs |
| Other Conditions Benign Prostatic Hypertrophy | 36 hrs |

(Include pregnancy within three months of death)
Date of operation 11/29/46
Major findings of operation B.P.H.
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Asher Hollander M.D.
Address Sinai Hospital Date signed 12/1/46

VS 150

G46079

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1930

G46079 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1365 n. Stockton st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1365 n. Stockton st (If rural give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Carter

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Fem.
5. Color or race Col.
6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-10-94

8. AGE: Years 52 | Months 6 | Days 21 | If less than one day hr. min.

9. Birthplace Florida (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant George Brown
(b) Address 1365 n. Stockton st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Halethorpe Balto. Co. Md.

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 922 n. Mount St.

19 (a) DEC — 5 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH (12-1) 11-30 1946, at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15, 1946 to 12-1- 1946, and that I last saw h alive on 11-30- 1946

| | Duration |
|---|---|
| Immediate cause of death: Cerebral Hemorrhage | 1 Day. |
| Due to: Hypertensive Heart | |
| Due to | |
| Other Conditions: Hemiplegia | 2 yrs. |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George P. Page M. D.
Address 1516 n. Mount St. (17) Date signed 12-2-46

VS 180

Kentucky

X

G46080

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V13B

G46080 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 215 N.Wolfe St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 215 N.Wolfe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Ida Parsons

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Jime Parsons
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): July 27, 1896
8. AGE: Years 50 | Months 4 | Days 3 | If less than one day hr. min.
9. Birthplace: Tenn. (Town, county, and state)
10. Usual Occupation: none
11. Industry or business

FATHER
12. Name: Eli Bishop
13. Birthplace: Tenn.

MOTHER
14. Maiden Name: Eliza Robinson
15. Birthplace: Tenn.

16 (a) Informant: Jime Parsons
(b) Address: 215 N.Wolfe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 3, 1946 (month) (day) (year)
(c) Cemetery or crematory: Mt. Carmel Cem.
Location: Balto. Md.

18 (a) Funeral director: Philip Hennighan
(b) Address: 2024 Orleans St.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC - 2 1946

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Nov. 30/46 19 , at M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 19 46 to Nov. 30 19 46.
and that I last saw h[illegible] alive on Nov. 30 19 46

Immediate cause of death: Cerebral A.S. — Duration: 1yr
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Harry Templeton M.D.
Address: 100 E Pratt St Date signed: 12/1/46

correct age is especially important. Physicians: please write the

G46081

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V47D

Registered No. G46081

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: U. S. Marine Hospital, Balto 11, Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Penna. (b) County —
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. 1722 Wallace Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Hugh Bostic Palmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | MARRIED |

6 (b) Name of husband or wife Mae Palmer
6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) May 14, 1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | 6 | 17 | hr. min. |

9. Birthplace Frederica, Delaware (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Merchant Seaman

FATHER
12. Name Hugh Palmer
13. Birthplace Smyrna, Delaware

MOTHER
14. Maiden Name Emma Folkner
15. Birthplace Frederica, Delaware

16 (a) Informant Hugh B. Palmer
(b) Address 1722 Wallace St. Phila, Pa.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec. 1, 1946 (month) (day) (year)
(c) Cemetery or crematory Barretts Chapel
Location Frederica - Delaware

18 (a) Funeral director E. Stewart Armacost
(b) Address 3911 Liberty Hghts. Ave

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 2 1946

Huntington Williams, MD

VS 100

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1 1946, at 7:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 1946 to Dec 1 1946, and that I last saw him alive on Dec 1 1946.

Immediate cause of death Metastatic CARCINOMA of BRAIN. — Duration

Due to Primary carcinoma left lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature V. J. Dorsett M.D.
Address U. S. Marine Hosp. Balto 11, Md. Date signed 12/1/46

G46082

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 111A

Registered No. G46082

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun St.
(c) Hospital or institution Franklin Square Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4004 Northern Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME E. Harry Baumann (or) Emanuel Henry Baumann

3 (b) If veteran, name war: War 1

3 (c) Social Security Account No. 705-07-8206

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M. | W. | M. |

6 (b) Name of husband or wife Barbara Baumann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 21 1893

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 11 | 10 | hr. min. |

9. Birthplace Howard Co. Md. (Town, parish, and state)
10. Usual Occupation Carpenter
11. Industry or business B. O. R. R.

FATHER
12. Name Philip Baumann
13. Birthplace Balto

MOTHER
14. Maiden Name Mary Schmidt
15. Birthplace Balto.

16 (a) Informant wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 4 46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd.

18 (a) Funeral director Martin H. C. Doppel & Son
(b) Address 3110 Belair Rd

19 (a) DEC - 2 1946 (Date received by registrar) Huntington, Maryland

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 1 1946, at 6:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 28 1946 to Dec. 1 1946, and that I last saw h-- alive on Nov. 30, 1946.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Embolism (Due to) | |
| Due to | |
| Due to | |
| Other Conditions Uremia | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. P. Friedman
Address 1319 Light St. Date signed 12/5/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 130

C46083 | Registered No. C46083

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 265. Durham St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 26 S. Durham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Katherine Younger
3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F. | W. | Married |

6 (b) Name of husband or wife Ira M.
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) July 6 1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | 4 | 24 | hr. min. |

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER 12. Name John Langerhr.
13. Birthplace Balto.

MOTHER 14. Maiden Name Sidney Root
15. Birthplace Balto

16 (a) Informant Ira M Younger
(b) Address 26 S. Durham St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/46 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location O'Donnell St.

18 (a) Funeral director M. W. E. Dippel's Sons
(b) Address Homewood & Ann Sts.

19 (a) (Date rec'd by registrar) DEC 1946 (b) Registrar

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Nov. 30 19 46 at 11:35 A.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from 10-17 1946, to 11-30 1946, and that I last saw her alive on 11-20 1946.

| Immediate cause of death | Duration ? |
|---|---|
| Pulmonary Tuberculosis | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Daniel Snyder, M. D.
Address 1634 E. Baltimore St. Date signed 12-2-46

Thursday for Mt Carmel

G46084

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G46084

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Westport
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2209 Annapolis Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Hugh Gallagher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1869

8. AGE: Years 76 | Months 11 | Days | If less than one day hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Glass blower

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Warren

(b) Address 2209 Annapolis Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 4-46 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Balto Md

18 (a) Funeral director Marine Cook Sykes

(b) Address 1600 W. North Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11/30/46 19 ; at 3:45 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John P. Davis M.D.
Medical Examiner.

Date signed 12/2/46

46085

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

93D

Registered No. G46085

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1117 Pine Heights
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 Pine Heights
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George E. Rauchhaus

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | married |

6 (b) Name of husband or wife Lina Schmidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16, 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 1 | 14 | hr. min. |

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Merchant

FATHER
12. Name Herman Rauchhaus
13. Birthplace Germany

MOTHER
14. Maiden Name Melitta —
15. Birthplace Germany

16 (a) Informant Mrs. Lina Rauchhaus
(b) Address 1117 Pine Height.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12.3.46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3501 Frederick Rd.

18 (a) Funeral director Harry A. Wilhelm
(b) Address 401 Edmondson Ave.

19 (b) DEC - 2 '46 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/21 1945 to 11/30 1946
and that I last saw h alive on 11/29 1946

Immediate cause of death Coronary Thrombosis — Duration 3 days
Due to Cardio-Vascular Disease — March 1944
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eliot W. Johnson M. D.
Address 2432 Madison Ave. Date signed 11/29/46

VS 150

X

46086 C. 25.00 To be typed X

BALTIMORE CITY HEALTH DEPARTMENT Medical G46086
Registered No.

# CERTIFICATE OF DEATH 1169

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 62 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Oakhill Cooks Lane (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Caroline Mizde. (Minde ✓

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband ~~or wife~~ deceased.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30, 1857

8. AGE: Years 89 | Months 8 | Days 1 | If less than one day — hr. — min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Carl Schultz
13. Birthplace Germany

MOTHER
14. Maiden Name Albertine —
15. Birthplace Germany

16 (a) Informant Mrs Frieda Lodl
(b) Address 726 Cottage Ave Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-46 (month) (day) (year)

(c) Cemetery or crematory Westerly
Location Edmondson Ave & Longwood St

18 (a) Funeral director Harry H. Wetzler
(b) Address 1101 Edmondson Ave

19 (a) DEC 2 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 1946, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-30-46 19..., to 12-1-1946, and that I last saw her alive on Dec 1 1946.

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia — terminal. | 7 days. |
| Due to Arteriosclerotic cardiovascular disease | |
| Due to Fracture — left hip | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 53.00
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Sept 29th at 11 P M
(c) Where did injury occur? Balto Balto Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Fell out of bed

23. Signature Chas. Jordan M. D.
Address Church Home Hospital Date signed Dec 1, 1946

For 5 Months. Referred by Dr Thomas J. Mencin, M.D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46087

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

131a

Registered No. G46087

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 696 Pierce St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) n'
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 696 Pierce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Arthur Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Jennetta Green

6 (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) Sept. 1883

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Hanover Co. Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name William C. Green

13. Birthplace Hanover Co. Va.

MOTHER 14. Maiden Name Mollie Burell

15. Birthplace Hanover Co. Va.

16 (a) Informant Carrie Adams

(b) Address 906 Argyle Ave.

17 (a) Burial Dec. 5, 1946 (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Beaver Dam

Location Va.

18 (a) Funeral director Mrs Katie R Williams

(b) Address 322 N Schroeder St

19 (a) (b) (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Nov 29 1946, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1946 to 11/29 1946, and that I last saw h alive on 11/28 1946

Immediate cause of death Chronic Myocarditis — Duration

Due to Hypostatic pneumonia — Duration

Due to — Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. T. Saunders M. D.

Address 12 W 20 Date signed 12/2/46

V S 150

Huntington Williams

G46088

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

168

G46088 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 903 Ryan St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Winfield S. Hunt

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife Elsie Hunt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 20, 1920

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 26 | 10 | 11 | hr. min. |

9. Birthplace Balto Co. (Town, county, and state)

10. Usual Occupation Punch - Steel Plant

11. Industry or business

FATHER
12. Name Wayne S. Hunt
13. Birthplace Balto Co.

MOTHER
14. Maiden Name Martha L. Tyndall
15. Birthplace Balto Co

16 (a) Informant Martha L. Hunt
(b) Address 903 Ryan St ~~S-46~~

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 5-46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Balto Co

18 (a) Funeral director J. F. Elmo Sons
(b) Address Reisterstown Md

19 (a) (Date rec'd by registrar) (b) Huntington Withdrawn, Md

VS 181
DEC -2 1946

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 1 1946, at 11:15 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture Skull
Intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 6-3

(a) Date of injury 12-1-46 at 11 P. M.
(b) Where did injury occur? Chester & Fairmount
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury (Pedestrian struck by auto)

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 12-2-46

X

G46089

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83B

G46089 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 645 W. Franklin street
(c) Hospital or institution:
17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 645 W. Franklin street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** IDA BELL SCAMMON

3 (b) If veteran, name war ----
3 (c) Social Security Account No. ----

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | white | Widow |

6 (b) Name of husband or wife Albert Q. Scammon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 26, 1863

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 7 | 2 | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name William E. Smith
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Schenkel
15. Birthplace Baltimore, Maryland

16 (a) Informant Mr. Frederic H. Carley
(b) Address 645 W. Franklin street

17 (a) Burial (b) Date thereof 12/2/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location

18 (a) Funeral director Chas. J. Cramer & Son Inc.
(b) Address 118 N. Mt. Royal Ave

19 DEC 2 1946 (b) Registrar
(Date rec'd by Registrar)

VS 150

DR. I. NELSON CAREY
1014 ST. PAUL STREET

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 19 46 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14 19 46 to 11-26 19 46 and that I last saw h[illegible] alive on 11-21 19 46

Immediate cause of death Cerebral Hemorrhage, Left — Duration 11 days
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Nelson Carey M. D.
Address 1014 St Paul St Date signed 12-9-46

G46090 ✓ X G46090

G46090

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 128

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Sparrows Point, Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1223 Beechwood R.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eli Sayberg (ELI JACOB SAXBERG)

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 236-12-3236

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: Divorced

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-26-08

8. AGE: Years 39 | Months 4 5 | Days 3 | If less than one day hr. min.

9. Birthplace W Va. (Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Lang & Sons

FATHER
12. Name Herman Sayberg
13. Birthplace Finland

MOTHER
14. Maiden Name Mary Hill
15. Birthplace Finland

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-46 (month) (day) (year)
(c) Cemetery or crematory OakLawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date received by Local Registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1946, at 7 25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 7 1946, to Nov. 29 1946, and that I last saw him alive on Nov. 29 1946.

| | Duration |
|---|---|
| Immediate cause of death: Generalized peritonitis | 1 day |
| Due to: Perforated marginal jejunal ulcer | 3 to 4 |
| Due to: | |
| Other Conditions: Sub-phrenic abscess | |

(Include pregnancy within 3 months of death)
Date of operation 11/14/46 & 11/21/46
Major findings of operation: (1) Peritonitis (2) Chr. Pancreatitis (3) Perf. ulcer (jejunal)
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry L. Bahrenburg M. D.
Address Johns Hopkins Hospital Date signed

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 450

G46091

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46091
Registered No. 129, 140C

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1906 McHenry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Elvira MAY CARR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Lenard Carr
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) April 29, 1912
8. AGE: Years 34 | Months 7 | Days 1 | If less than one day ____hr. ____min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Meter Reader
11. Industry or business Sun Gas Co.
FATHER 12. Name William Dorner
FATHER 13. Birthplace Maryland
MOTHER 14. Maiden Name Mary E. Eisenbough
MOTHER 15. Birthplace Maryland.
16 (a) Informant Mary E. Spengel
(b) Address 519 S. Bentalou St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.
18 (a) Funeral director George L. Schwab
(b) Address 2101 Fred'k. Ave.
19 (a) 2 1946 (Date rec'd by registrar) (b) Clinton Williams, Registrar

VS 181

**MEDICAL CERTIFICATION**

20. DATE OF DEATH November 30 1946, at 2.20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Peritonitis

Due to Abortion, probably self-induced

Other Conditions (over)

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 12/2/46

X

G46092

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46092 Registered No. 93D

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1907 Regester St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Jacob Foellinger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ethel Foellinger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4 - 1845

8. AGE: Years 60 | Months 4 | Days 27 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Germany

MOTHER 14. Maiden Name Unknown

15. Birthplace Germany

16 (a) Informant Mrs Aforanzin

(b) Address 1749 N Castle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3rd 1946 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Gaylor Ave

18 (a) Funeral director Leo G. Lerch

(b) Address 1701-03 N. Pattenson Park Ave

19 (a) DEC 2 1946 (b) (Date received by registrar) Huntington Williams, Registrar

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/1 1946, at 7:25 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to h-s death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic CV disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. J. Turbeville M.D. Medical Examiner.

Date signed 12/2/46

G46093
504294.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1240

Registered No. G46093

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 924 N. Eaden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earnest Wainwright

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Ethel
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 8-1-92.

8. AGE: Years 54. | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation B & O. R. R.

11. Industry or business

FATHER 12. Name George Wainwright
13. Birthplace Md.

MOTHER 14. Maiden Name Mary Harrison
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Fem Xing

18 (a) Funeral director Raymer Sandoval
(b) Address 1412 E. Preston St

19 (a) [illegible] (b) [illegible]
(Date received by Registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Nov. 30 1946, at 1227 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 1946, to Nov. 30 1946 and that I last saw him alive on Nov. 30 1946.

Immediate cause of death Cirrhosis of the liver, chronic — Duration >5 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation Nov. 26, 1946
Major findings of operation: Cirrhosis of the liver, severe, chronic
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bruce J. Fraser M.D.
Address The Johns Hopkins Hosp. Date signed 11/30/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Mc Dermott

1136 Poplar Grove St

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. C16094

1136 Poplar Grove St C16094 ✓ 947

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Oakhurst Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 Oakhurst Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ben Riley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ena Ellen Riley

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) July 10 - 1883

8. AGE: Years 63 | Months 4 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace Chambersburg Pa.
(Town, county, and state or foreign country)

10. Usual Occupation Athletic Director

11. Industry or business

FATHER
12. Name William Riley
13. Birthplace Chambersburg Pa.

MOTHER
14. Maiden Name Anna Dietrich
15. Birthplace Chambersburg Pa.

16 (a) Informant Ena Ellen Riley
(b) Address 1211 Oakhurst Place

17 (a) Burial (b) Date thereof 12-3-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Our Cathedral
Location Balto Md

18 (a) Funeral director Thomas J. Kenny Inc.
(b) Address Collins & Fulmore Sts

19 (a) (Date rec'd by registrar) DEC 2 1946 (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1st 1946, at 1.15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1st 1946, to Dec. 1st 1946, and that I last saw h[illegible] alive on Dec. 1st 1946.

| | Duration |
|---|---|
| Immediate cause of death Coronary occlusion | 3 hrs. |
| Due to Arteriosclerosis | 1 |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. M. Dermott M. D.

Address 1136 Poplar Grove St Date signed 12/2/46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-Transcript

G46095

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 16

✓ G46095 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Childrens Hospital School 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs-120 days
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 760 Herring Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Emanuel Eugene Hickey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-31-40

8. AGE: Years 6 | Months 4 | Days | If less than one day ____ hr. ____ min.

9. Birthplace Harlan County, Ky. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Emanuel D Hickey
13. Birthplace Mt Vernon Ky

MOTHER
14. Maiden Name Elva Hickey
15. Birthplace Mt Vernon Ky

16 (a) Informant Father
(b) Address above

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3-46 (month) (day) (year)
(c) Cemetery or crematory Elmwood
Location Mount Vernon - Kentucky

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) DEC 2 1946 (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 1 1946 at 6 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-26 1946 to 12-1 1946 and that I last saw h 1 alive on Dec. 1 1946.

Immediate cause of death Tubercular Meningitis — Duration

Due to Tuberculosis of Spine

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm J Wilson M. D.
Address Childrens Hosp. School Date signed 12-1-46
Baltimore, Md.

VS 8

G46096

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

Registered No. X G46096

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Dumeland & Rayner Ave
(c) Hospital or institution:
West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Reisterstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. Bond Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** TURNER WILLIAMS ISAAC

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Katherine Morrison Isaac
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 21, 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 6 | 10 | hr. min. |

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual Occupation: Lumber Business
11. Industry or business: Self

FATHER
12. Name: Joseph Isaac
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Jennie Gordon
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mr. J. E. Kirkley
(b) Address: 308 Farwood Rd., Phila., Pa.

17 (a) Burial (b) Date thereof 12/3/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (b)
(Date received by registrar) Registrar

DEC 2 1946

VS 190

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12-1 1946, at 7:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27 1946 to 12-1 1946, and that I last saw h. alive on 12-1 1946.

| Immediate cause of death | Duration |
|---|---|
| 1. Ventricular Fibrillation | |
| 2. Ventricular | |
| Due to: Tachycardia | |
| 3. Coronary Thrombosis | |
| Due to: 4. Arteriosclerotic Heart Disease | |
| Other Conditions: URINARY SHUTDOWN | |

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Benjamin Berlinsky, M.D.
Address: NBGH Date signed: 12-1-46

X

G46097

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓61

G46097

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1534 Carswell St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel Louise McComas

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Herbert Hunter McComas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 17, 1882

8. AGE: Years: 64 Months: 9 Days: 14 If less than one day: hr. min.

9. Birthplace: Harford Co., Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: Walter Stansbury
13. Birthplace: ~~Baltimore Co.~~ Harford Co., Md.

MOTHER
14. Maiden Name: ~~Pauline McClellan~~ McClellan
15. Birthplace: ~~Harford Co., Md.~~ Phila. Pa.

16 (a) Informant: Mrs. Charles R. Young
(b) Address: 1534 Carswell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/46 (month) (day) (year)

(c) Cemetery or crematory: Parkwood Cem.
Location: Baltimore, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) DEC 2 1946 (Date rec'd by registrar) (b) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1st 1946, at 1.25 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/21 1946, to 12/1 1946, and that I last saw her alive on 12/1 1946.

| Immediate cause of death | Duration |
|---|---|
| Heart failure | |
| Due to Cerebral thrombosis | |
| Due to H. C. V. Disease | 10 days |
| Other Conditions Hypertension, arteriosclerosis, non-toxic goitre | |

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: C. B. Gonzalez M. D.
M. D.
Address: Maryland G. Hospital Date signed 12/1/46

Huntington Ave

G46098

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G46098

Please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1731 Rutland Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 67 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1731 Rutland Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Emma L. Conrad

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Henry Conrad
6 (c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.): Aug. 9th., 1863

8. AGE: Years: 83 | Months: 3 | Days: 20 | If less than a day: ######## hr. ____ min.

9. Birthplace: Germany (Town, county, and state)
10. Usual Occupation: At Home
11. Industry or business:

FATHER
12. Name: Diedrich A.A. Nobbe
13. Birthplace: Germany

MOTHER
14. Maiden Name: Friederike E. Schurmann
15. Birthplace: Germany

16 (a) Informant: Mr. Alexander Conrad (Son)
(b) Address: 1731 Rutland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12/3/46 (month) (day) (year)
(c) Cemetery or ######: Baltimore
Location: E. North Avenue

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) ____ (b) ____ Registrar
(Date rec'd by registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 29 Nov., 1946, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 20 Nov 1946 to 29 Nov 1946 and that I last saw h[illegible] alive on 29 Nov 1946.

| Immediate cause of death | Duration |
|---|---|
| a [illegible] | 3 Days |
| Due to [illegible] | |
| Due to | |
| Other Conditions [illegible] | |

(Include pregnancy within 3 months of death)

Date of operation: —
Major findings of operation:
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 115 E. Eager St. Date signed 29 Nov 46

[illegible] Huntington Hill

97

Dr G46099
6232 Belair Road

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 1930

Registered No. G46099

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1512 E. Oliver St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 E. Oliver Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William H. Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Mary Ann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 10 | 13 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation B.T.Co
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Mary ANN Williams
(b) Address 1512 E. Oliver Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5309 Harford Road

19 (a) (b) Registrar
(Date received by registrar)
DEC 2 1946 Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Nov. 29th, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 11 1946 to Nov. 29 1946 and that I last saw h[illegible] alive on Nov. 26 1946

Immediate cause of death Coronary thrombosis — Duration ½ hours
Due to Arteriosclerotic Heart Disease — Duration unknown
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Adam G. Lewis M. D.
Address 6232 Belair Rd. Date signed Nov. 30, 1946

G46100

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

138

Registered No. G46100

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 926 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Howard Patterson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/19/94

8. AGE: Years 57 | Months 11 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER
12. Name George Elliott Patterson
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Stevens
15. Birthplace Md.

16 (a) Informant Mrs. Catherine Patterson
(b) Address 926 E. Balto St.

17 (a) Burial (b) Date thereof 12-4-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Leuck
(b) Address 5305 Harford Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 1st 1946, at 4:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1946, to Dec. 1 1946 and that I last saw h. in alive on Dec. 1 1946

| Immediate cause of death | Duration |
|---|---|
| Cardiorespiratory failure | |
| Due to Cerebral Hemorrhage | |
| Due to Hypertension, | |
| Other Conditions Epistaxis | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]

Address [illegible] Date signed 12/1/46
M. D.

VS 150 DEC - 2 1946 Huntington Williams, M.D.

G46101 P.L. G-63789

G46101

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 160 A

Registered No. G46101

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: Univ. of Maryland Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) less 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) Penna. Ave
(d) Street No. 1123 Pennsylvania Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Morrison
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: none
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11/28/46
8. AGE: Years 0 | Months 0 | Days 0 | If less than one day 17 hr. 50 min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name William Morrison
13. Birthplace Augusta, Ga.

MOTHER
14. Maiden Name Inez Williams
15. Birthplace Augusta Ga.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 2 1946

18 (a) Funeral director Commissioner of Health
(b) Address

DEC 2 1946 Date rec'd by registrar Huntington Williams M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11/28 1946, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/28 1946, to 11/28 1946, and that I last saw h.e.r. alive on 11/28 1946.

| Immediate cause of death | Duration |
|---|---|
| Asphyxia | |
| Due to Intracranial hemorrhage | |
| Due to Birth trauma | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: Marked cerebral congestion Dilat. tortuous pulmonary

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Gregg M. D.
Address University Hospital Date signed 11-29-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

46102 Linda Lee Ofgletree D-64357

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

G46102
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 736 W. Dontaga St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 736 W Dontaga St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Linda Ofgletree Rogers

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | black | single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 0 | 0 | 1 hour | 1 hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Clarence Rogers
13. Birthplace North Carolina

MOTHER
14. Maiden Name Mabel Margaret McLaurin
15. Birthplace Asheville North Carolina

16 (a) Informant Mabel Margaret McLaurin Rogers
(b) Address 736 W. Dontaga St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 DEC 2 1946 (Date rec'd by registrar) Huntington Williams Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1, 1946 19 , at 12:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30 1946 to Dec. 1 1946 and that I last saw her alive on Dec. 1 19 46.

Immediate cause of death Prematurity

Due to immaturity of organs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. L. Ferguson M. D.
Address R. L. Ferguson Date signed
K University Hosp.

University Medical School DEC 2 1946
Commissioner of Health

G46103

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

UNK-105550 / 93D

G46103 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Balto City Hospitals 51
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 68- 10- 26-

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Block Orleans Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** William Beckett

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Separated |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 25-1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 10 | 26 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 2 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 2 1946 (Date rec'd by registrar) (Signature) Huntington Williams

**MEDICAL CERTIFICATION**

20. DATE OF DEATH November 21 1946, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 25 1946 to Nov. 21 1946 and that I last saw h. 1m alive on Nov. 21 1946

Immediate cause of death: (a) Cerebral vascular accident — Duration

Due to: Hypertensive C. V. disease

Due to:

Other Conditions: Old hemiplegia, rt.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Dayle Waldron M. D.
Address B. C. H. Date signed 11/26/46

VS 150

G46104 G46104

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13 A

Registered No.

Ts. 16214

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18- 8-23 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 336 Dover St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mamie Wheeler or Mary Wilson

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Col. | Widow |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11th 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 5 | 11 | hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Wheeler
13. Birthplace ?

MOTHER
14. Maiden Name Elizabeth Thomas
15. Birthplace Baltimore

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records )

17 (a) (Burial, cremation, or removal) (b) Date thereof (Month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 2 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 2 1946 (Signature of local registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Nov. 22/1946 19 at 9.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 29/ 19 28 to Nov. 22 19 46, and that I last saw h er alive on Nov. 22nd 19 46

Immediate cause of death: Carcinoma vaginal cervix — Duration 5 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Randall Hoff M. D.
Address Baltimore City Hosp. Date signed 12/2/46

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46105 Birth Certificate G.6425 — Stenowich — G46105

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 116

Registered No.

Please write the causes of death clearly and legibly. Physician: please write

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1213 Lytle Street
(c) Hospital or institution: South Balto. Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town Baltimore 24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 831 S. Decker Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy Stanowich

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | — |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 2 | hr. min. |

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name John Stanowich
13. Birthplace Poland

MOTHER
14. Maiden Name Agnes Rozanski
15. Birthplace South Bend, Indiana

16 (a) Informant Mother
(b) Address 831 S. Decker Ave.

17 (a) Burial (b) Date thereof Dec. 3/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Fred W. Ozaguerki
(b) Address 1930 Fenton Ave.

19 (a) (b)
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 2 December 1946, at 5:20 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 30 Nov 1946, to 2 Dec 1946, and that I last saw him alive on 2 Dec 1946

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| (Aspiration) Asphyxia | |
| Due to Obstruction middle 1/3 Esophagus | |
| Due to Esophageal-tracheal fistula | |
| Other Conditions Premature birth at 4th mo. | |
| (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy: Esophageal obstruction

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Cohen M. D.
Address South Balto Gen'l Hosp Date signed 2 Dec 46

VS 150

G46106 BC# #50745 BALTIMORE CITY HEALTH DEPARTMENT G46106
CERTIFICATE OF DEATH 107
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1920 E Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1920 E Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Kay Hardin

3 (b) If veteran, name war W
3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2. 1946

8. AGE: Years | Months 4 | Days 29. | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

MOTHER FATHER

12. Name James D Hardin
13. Birthplace West Virginia
14. Maiden Name Kathryn Pochelon
15. Birthplace Baltimore Md

16 (a) Informant James D Hardin
(b) Address 1920 E Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Md

18 (a) Funeral director Hulbert Robbins
(b) Address 1317 E Pont St

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

DEC -3 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 1946, at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1946 to Dec. 1 1946, and that I last saw h.e.r. alive on 11-28 1946.

| Immediate cause of death | Duration |
|---|---|
| Acute Bronchio-Pneumonia | 1 day |
| Due to upper Respiratory infx | 3 days |
| Due to — | |
| Other Conditions Prematurity (Child born at 30 Lunar Weeks) | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl Pass MD
Address 600 Wilkens Ave Date signed 12-2-46
M. D.

Write the causes of death clearly and legibly.

G46107

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G46107

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore City Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 13 Belle Grove Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Samuel L. Blume

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M. |

6 (b) Name of husband or wife Carmelita

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 25 (1894) 1892

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| (1894) 54 | 8 | 6 | hr. min. |

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Composition
11. Industry or business Sun papers

FATHER
12. Name ? Blume
13. Birthplace Unknown

MOTHER
14. Maiden Name Josephine Krupp
15. Birthplace Unknown

16 (a) Informant Carmelita Blume
(b) Address 3 Belle Grove Rd Caton.

17 (a) Burial (b) Date thereof 2/7/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Baltimore Md
18 (a) Funeral director Wm Cook Sons
(b) Address 217 St Paul St.
19 (a) (b) Huntington Williams
(Date rec'd by registrar)

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/1 1945 2:35 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Pelzmeier M.D.
Medical Examiner.
Date signed 12/1/45

G46108 G46108

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3126 Abell Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3126 Abell
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Homer Winne

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: 213-01-2554

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alma Clark Winne

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 27, 1876

8. AGE: Years: 70 | Months: 5 | Days: 5 | If less than one day: hr. min.

9. Birthplace: Albany, N. Y. (Town, county, and state)

10. Usual Occupation: Retail Buyer

11. Industry or business: Eastman Kodak Co.

FATHER
12. Name: Eugene Winne
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Nellie Sprague
15. Birthplace: Unknown

16 (a) Informant: Mrs. Alma C. Winne wife
(b) Address: 3126 Abell Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12/4/46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) Washington Williams, M.D. Registrar

DEC 13 1946

VS 185

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/2/46 19 , at 7:10 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Myocardiac Cardiovascular Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: John R. Watts M.D. Medical Examiner.
Date signed: 12/3/46

X

G46109

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 B

G46109 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 405 S. Chapel Street
(c) Hospital or institution: 2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 S. Chapel Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles August Zinkand

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-5328

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-5-1884

8. AGE: Years 62 | Months 4 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Harry Zinkand
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Sophia Saunders
15. Birthplace Baltimore Maryland

16 (a) Informant Anna Loftus
(b) Address 405 S. Chapel Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd. Balto.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 E. Lafayette Street

19 (a) (Date rec'd by registrar) (b) Clayton Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 2 1946 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20 1946 to Dec. 2 1946 and that I last saw h.... alive on Dec. 2 1946

Immediate cause of death: Carcinoma of stomach with metastases — Duration: —
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Mary J. Seavolos M. D.
Address 700 E. Lafayette Ave. Date signed 12/3/46

VS 150

G46110

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 55E

G46110 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2228 Cecil Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2228 Cecil Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas F. Reardon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Wilhelmina Reardon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 12 - 1865

8. AGE: Years 78 | Months 1 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Jeremiah Reardon

13. Birthplace England

MOTHER 14. Maiden Name Catherine Base

15. Birthplace Baltimore Md

16 (a) Informant Anna M. Franke

(b) Address 2228 Cecil Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 6-46 (month) (day) (year)

(c) Cemetery or crematory: Loudon Park Cem

Location

18 (a) Funeral director: Charles C. Powell

(b) Address 2427 E. Monument Ave

19 (a) (b)

(Date rec'd by registrar) DEC 3 1946

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 1 1946 at 2.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1926 to Dec 1 1946 What I last saw him alive on Dec 1, 1946

| | Duration |
|---|---|
| Immediate cause of death: Myocardial Insufficiency | 4 days |
| Due to: Myocarditis | 6 mos |
| Due to: Arteriosclerosis | 10 years |
| Other Conditions: Epistaxis, Uremia | 94 yrs |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Waxter M. D.

Address 532 E. 22nd St. Date signed 12/4/46

X

G46111

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

G46111 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4311 Groveland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4311 Groveland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Anna S Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860

8. AGE: Years 86 | Months – | Days – | If less than one day hr. min.

9. Birthplace Pittsburgh Pa (Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Andrew Cummings Evans
13. Birthplace Pittsburgh Pa.

MOTHER
14. Maiden Name Elizabeth Bateman
15. Birthplace Pennsylvania

16 (a) Informant Mrs Elizabeth B. Hill
(b) Address 4311 Groveland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-4-46 (month) (day) (year)
(c) Cemetery or crematory Perryville Cem.
Location Pittsburgh, Pa.

18 (a) Funeral director J. Hilton Wiedefeld
(b) Address Greenmount & 22nd

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 3 1946 Washington, D.C.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2. 1946, at 8:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 30th 1946, to Dec 2 1946, and that I last saw h[illegible] alive on Dec. 1 1946.

Immediate cause of death Cerebral Hemorrhage — Duration Nov 30th until Dec 2/46

Due to ~~[illegible]~~ Arteriosclerosis — Duration

Due to old age — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr George Triefenthal M. D.
Address 1814 Eutaw Place Date signed Dec 2, 1946
Baltimore, Md

G46112

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 195E

G46112 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 Caroline St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

**3 (a) FULL NAME** Sarah Jackson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | |

6 (b) Name of husband or wife Gresta Jackson. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15 - 1916

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 30 | 5 | 14 | .....hr. .....min. |

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name George Jacobs
13. Birthplace A. A. Co. Md

MOTHER 14. Maiden Name Estella Barnes
15. Birthplace A A Co. Md.

16 (a) Informant Sister
(b) Address 608 Baker St

17 (a)..... (Burial, cremation, or removal) (b) Date thereof 12 6 46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Balto.

18 (a) Funeral director Walter B. Sprigg
(b) Address 139 William St.

19 (a) DEC - 3 1946 (Date rec'd by reg.) Huntington Md Registrar

VS 161

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 2 1946, at 9:30 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH..... fractured skull

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? Unknown While at work?.....
(d) Means of injury.....

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 12/2/46

X 595

G46113

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

Registered No. G46113

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett Ave.
(c) Hospital or institution:
Pine Ridge Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-5
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6437 Cedonia Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARGARET A. MASER

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife George A. Maser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. Walter Maser
(b) Address 6704 Beech Ave.

17 (a) burial (b) Date thereof Dec. 4, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto., Md.

18 (a) Funeral director Lansdale Funeral Home
(b) Address 7401 Belair Road

19 (a) DEC 3 1946 Registrar
(Date filed by registrar)

Courtesy of Maryland Department of Health. Please write the causes of death clearly and legibly.

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 1st, 1946 at 7:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 9th 1946 to Dec 1st 1946, and that I last saw h[illegible] alive on Dec 1st 1946.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | Nov 9th |
| Due to Arteriosclerosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elliott Benson M. D.
Address 1 W. Preston St. Date signed 12/3/46

Certificate filed in Baltimore, Md.

VS 150

G46114

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1312

G46114
Registered No.

Correct age is especially important. Physician: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1300 W. Cold Spring Lane
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1300 W. Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

15

**3 (a) FULL NAME** Effie M. Mackin.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | white | married |

6 (b) Name of husband or wife Joseph H. Mackin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 19, 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 10 | 12 | hr. min. |

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Daniel W. Price.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Susanne Stiffler
15. Birthplace Maryland.

16 (a) Informant Clarence D. Mackin
(b) Address 1300 W. Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 4/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Thomas F. Donovan
(b) Address 3615-17 Chestnut Ave.

19 DEC 3 1946 Registered by Registrar Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 1, 1946, at 6 30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1946 to Dec 1 1946 and that I last saw her alive on 11-29 1946.

Immediate cause of death: Arteriosclerotic CVD & Decomp. — Duration: 2

Due to:

Due to:

Other Conditions Chronic Nephritis — 1

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence J. Slemaneck M.D. M. D.
Address 3716 Falls Rd Date signed 12-1-46

VS 150

937

G46115 G46115

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 109a

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1502 Olmsted St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Harry Matuszewski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Marion Matuszewski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 30, 1910

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 36 | 1 | 1 | hr. min. |

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Welder
11. Industry or business Procter & Gamble

FATHER
12. Name Anthony Matuszewski
13. Birthplace Poland

MOTHER
14. Maiden Name Stella Osgist
15. Birthplace Poland

16 (a) Informant Marion Matuszewski
(b) Address 1502 Olmsted St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-4-46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Balto. Md.

18 (a) Funeral director Wm. J. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) Dec 3 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 1 1946, at 12:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 26 1946, to Dec 1 1946, and that I last saw him alive on Dec 1 1946.

| Immediate cause of death | Duration |
|---|---|
| Respiratory Failure | |
| Due to Pulmonary Virus Pneumonia | 5 days |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry De'Lee M. D.
Address 1226 Hanover St. Date signed 12/1/46

VS 150

G46116

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G46116 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Baltimore Gen'l Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4511 Pennington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Bernadyn

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed or divorced |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Mamie Bernadyn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business Self
12. Name Mary Konopasha
13. Birthplace Poland
14. Maiden Name Stephen Bernadyn
15. Birthplace Poland
16 (a) Informant Michalina Bernadyn
(b) Address 4511 Pennington Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location R. R. Co.
18 (a) Funeral director Wm. L. Fialkowski
(b) Address 2007 Eastern Ave
19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 1 1946 at 1:25 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1946 to Dec 1 1946 and that I last saw h. alive on Dec 1 1946

| Immediate cause of death | Duration |
|---|---|
| Acute Cardiac Failure | |
| Due to Coronary occlusion | |
| Due to Hypertensive Heart Disease | |
| Other Conditions Malignant hypertension | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Thomas M. Hulehan M. D.
Address 8 Bolton Terr. Hosp. Date signed 12-1-46

VS 150

G46117

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46117 Registered No. 12463

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4200 Potter st
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4200 Potter st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Catherine S. Horn

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Nathan L. Horn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23-1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 9 | 7 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name James E. Schmidt
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Mary A. Connelly
15. Birthplace Balto Md

16 (a) Informant Mr. Nathan L. Horn
(b) Address 4200 Potter St

17 (a) Burial (b) Date thereof 12-3-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Geo. L. Beyer Jr
(b) Address 1512 Hollins St

19 (a) (b)
(Date rec'd by registrar) Registrar

DEC - 3

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11/30/46 19 , at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1945 to Nov 30 1946 and that I last saw her alive on Nov 29 1946.

Immediate cause of death

| | Duration |
|---|---|
| Cirrhosis of the liver | 1½ yrs |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury
23. Signature A. Pales M. D.
Address 47 Fulton Date signed

Write the causes of death clearly and legibly.

G46118

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered G46118

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 243 N Monastery Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 T
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 243 N Monastery Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary M Schroeder

3 (b) If veteran, name war: N
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16 1862

8. AGE: Years 84 | Months 9 | Days 16 | If less than one day: hr. min.

9. Birthplace York Co Pa (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Dell
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Walter "Schroeder
(b) Address 243 N Monastery Ave

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof (month) Dec (day) 5 (year) 46
(c) Cemetery or crematory Greenmount Crema
Location York, Pa

18 (a) Funeral director Wilhom Cole Inc
(b) Address 1217 E Fayette St

19 (a) (Date rec'd by registrar) DEC 5 1946 (b) Registrar Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 2 1946, at 11.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1946 to Dec 2 1946, and that I last saw h alive on Dec 2 1946.

| | Duration |
|---|---|
| Immediate cause of death: myocardial insuff | |
| Resulting from: arteriosclerotic type | |
| Heart disease with hypertension | |
| Due to: Phlebitis and congestive | |
| Failure. | |
| Due to: Generalized arterio | |
| sclerosis | |
| Other Conditions: Pernicious anaemia | 12 yrs. |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W Michel M. D.
Address 2901 Edmondson Ave Date signed Dec 3 46

X

46119

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 55E

G46119
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3233 Powhattan Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Theodore Halpern

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Estelle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER
12. Name Samuel
13. Birthplace Russia

MOTHER
14. Maiden Name Dadee
15. Birthplace Russia

16 (a) Informant Estelle Halpern
(b) Address 3233 Powhattan Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-46 (month) (day) (year)

(c) Cemetery or crematory
Location New York, N.Y.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E Balto St

EG (d) 3 1946 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2/46 1946 at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15 1946 to 12/2 1946 and that I last saw h[illegible] alive on 12/2 1946

Immediate cause of death cachexia — Duration

Due to Lymphosarcoma pelvis

Due to

Other Conditions A.C. Colitis & disease hydro nephrosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Heinz Biesinger

Address Sinai 6 Date signed M/D 12/2/46

VS 150

16120

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46120 Registered No. 1310

Please write the ranks of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland Franklin Sq. Hosp.
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Sq. Hosp. 19-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 410 N. Bruce St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country.

**3 (a) FULL NAME** Wellsetta Rosetta Talbot

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: single

(b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 52 | Months | Days | If less than one day hr. min.

9. Birthplace Md Baltimore (Town, county, and state)

10. Usual Occupation Day's work

11. Industry or business

FATHER 12. Name William Talbott

13. Birthplace Balto Md

MOTHER 14. Maiden Name Henrietta Hill

15. Birthplace Balto Md

16 (a) Informant William Talbot

(b) Address Lafayette 1981

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3 1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St

19 (a) Dec 3 1946 (b) (Date rec'd by registrar) Registrar for Baltimore City

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 11/30 1946, at 1:45 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from 11/30 1946 to 19 , and that I last saw her alive on 11:30 A.M. 19 11/30/46

| Immediate cause of death | Duration |
|---|---|
| Acute Left heart failure | |
| Due to Cerebral Hemorrhage | |
| Due to | |
| Other Condition Left Hemiplegia | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Moderate Cerebral Sclerosis and Nephrosclerosis

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

**23.** Signature R. H. Williams M. D.

Address Franklin Square Hosp. Date signed 12-3-46

VS 180

830 46

6121

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G46121 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1615 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Annie Elnora Hynson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Samuel Hynson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1880

8. AGE: Years 66 | Months 6 | Days 3 | If less than one day: hr. min.

9. Birthplace W. Pittsman Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Thomas

13. Birthplace Talbot Co. Md.

MOTHER 14. Maiden Name Georgianna Bush

15. Birthplace Talbot Co. Md.

16 (a) Informant Sarah Cephas

(b) Address 1615 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 4 1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location

18 (a) Funeral director Mrs Kytie R. Williams

(b) Address 322 N Schroeder St.

19 (a) DEC - 3 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Nov. 30 1946 at 10 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1946 to Nov. 30 1946 and that I last saw h[illegible] alive on Nov. 30 1946

| Immediate cause of death | Duration |
|---|---|
| Congestive Heart Failure | 1 week |
| Due to Hypertension | |
| Due to Cerebral Vascular Disease | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph W. Hallman M.D.

Address 4704 Park Ave Date signed 12/3/46

V S 150

G46122

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 48a

Registered No. G46122

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address CATON & HILKENS
(c) Hospital or institution:
ST. AGNES HOSP 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1911 W. BALTO. ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET W. MERCIER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife ROBERT LEE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/13/1851

8. AGE: Years 65 | Months 4 | Days 18 | If less than one day — hr. — min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual Occupation Housewife at Home

11. Industry or business

FATHER
12. Name John W. McCORMICK
13. Birthplace IRELAND

MOTHER
14. Maiden Name Margaret ?
15. Birthplace IRELAND

16 (a) Informant Robert Lee Mercier
(b) Address 1911 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 Dec 46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore - Md.

18 (a) Funeral director C. B. Wehrle & Son
(b) Address 1124 Eutaw Place

19 (a) 12-9-1946 (Date rec'd by registrar) Washington Willis (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/1 1946, at 6:25 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/26 1946 to 12/1 1946, and that I last saw her alive on 12/1 1946.

Immediate cause of death: heart failure | Duration
Antecedent Carcinoma of Pancreas
Conditions Cancer of Pancreas
Due to Hydronephrosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J W Murtha M. D.
Address St Agnes Date signed 12-7-46

VS 150

G46123

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1310

Registered No. G46123

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1505 E. Chase St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 1506 E. Chase St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lydia Barnes (Boulé)

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Israel Barnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 19 ?

8. AGE: Years Apx. 90 | Months 2 | Days 11 | If less than one day hr. min. 1876

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife.
11. Industry or business

**FATHER**
12. Name John Crowley.
13. Birthplace Md.

**MOTHER**
14. Maiden Name Margaret —
15. Birthplace Md.

16 (a) Informant Margaret Nelson
(b) Address 1506 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 4 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location

18 (a) Funeral director Robert L. Young
(b) Address 1262 N. Caroline St.

19 (a) DEC 3 1946 (Date rec'd by registrar) (b) Huntington for Williams Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH November 30 1946, at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1946 to Nov 30 1946, and that I last saw h[illegible] alive on Nov 24 1946.

Immediate cause of death Chronic Nephritis — Duration Complete

Due to

Due to

Other Conditions Hypertension Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph L. Young M. D.
Address 1429 E. Monument Date signed 12/2/46

Correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS 150

46124

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G46124 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Dukeland & Rayner
(c) Hospital or institution:
West Baltimore Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3510 Elm Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Edward Burns

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| — | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widower |

6 (b) Name of husband or wife Anna E. Burns
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21-1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 10 | 11 | hr. min. |

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Machinist (Pa. R.R.)
11. Industry or business Retired 10 years

FATHER
12. Name William Burns
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha
15. Birthplace Maryland

16 (a) Informant Mrs. Dorothy Brooks
(b) Address 3510 Elm Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 5-1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Royal Hampden
Location Baltimore, Maryland

18 (a) Funeral director Burgan Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date rec'd by Registrar) (b) Signature for Williams Registrar

DEC 5 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-2 1946, at 4⁰⁵ A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-26 1946, to 12-2 1946, and that I last saw him alive on 12-2 1946.

Immediate cause of death Pulmonary Edema — Duration

Due to Arteriosclerotic Heart Disease

Due to Generalized

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Berdeny M. D.
Address UBCH Date signed 12-2-46

VS 150

X

G46125

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 108

G46125 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts.
(c) Hospital or institution Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) Just came.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Harford
(c) City or town Havredegrace
(If outside city or town limits, write RURAL and give town)
(d) Street No. 315 Treadon St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nettie Harding

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F. | B | M |

6 (b) Name of husband or wife Charles Harding
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1922

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 24 | | | hr. min. |

9. Birthplace Havredegrace (town, county, and state)
10. Usual Occupation Elevator operator
11. Industry or business

FATHER
12. Name George Wallace
13. Birthplace Virginia

MOTHER
14. Maiden Name Nellie Haycock
15. Birthplace Maryland

16 (a) Informant Nettie Harding
(b) Address (Deceased)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/5/46 (month) (day) (year)
(c) Cemetery or crematory St. James
Location Route 40 Grace Rd

18 (a) Funeral director Fleury & Bielot
(b) Address 55 S. Lewis St. Havredegrace

19 DEC -3 1946 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-2 1946, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-2 1946 to 12-2 1946 and that I last saw her alive on 12-2 1946.

| Immediate cause of death | Duration |
|---|---|
| Cardio respiratory failure | |
| Due to Asphyxia - intra-tracheal hemorrhage | |
| Due to Lobar pneumonia | |
| Other Conditions Arteriosclerosis - syphilis not def. | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E May M. D.
Address Calvert + Saratoga Date signed 12-2-46

VS 150

G46126

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 166

G46126 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Martin Luther Savage

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1929

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 17 | 6 | 9 | hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Rev. George H. Savage
13. Birthplace Greenville S. C.

MOTHER
14. Maiden Name Mary L. McCowan
15. Birthplace North Carolina

16 (a) Informant Rev. George H. Savage
(b) Address 700 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 5, 1946 (month) (day) (year)
(c) Cemetery Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director A. G. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) DEC 3 1946 (Date received by registrar) (b) Huntington Williams (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11-30-1946, at 2 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wound of abdomen involving common iliac artery & large intestines.
Due to Hemoperitoneum

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11/29/46 at 9:45 P. M.
(b) Where did injury occur? 920 Druid Hill Ave Restaurant
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Shot during altercation

23. Signature Homer J. Madeira M.D.
Medical Examiner.
Date signed 11-30-46

VS 181

X

G46127

G46127

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V46F

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home + Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13.
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6606 Fairfield Ave (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country German

**3 (a) FULL NAME** Mr. Christian Hermann

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed.

6 (b) Name of husband or wife: Mrs. Marie Hermann

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 9/2/1890

8. AGE: Years 56 | Months 02 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace German (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Clothing

FATHER
12. Name Christian Hermann
13. Birthplace German

MOTHER
14. Maiden Name Johanna Wennekamp
15. Birthplace German

16 (a) Informant Mr. Albert Hermann
(b) Address 1202 St. Paul St.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12/4/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St.

19 (a) Huntington Williams, M.D. (Delivered by registrant) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 2, 1946, at 8 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 19, 1946, to Dec 2 1946, and that I last saw h[illegible] alive on Dec 2, 1946.

Immediate cause of death: Primary Carcinoma of Gall Bladder with metastasis to the liver — Duration 6 mos.
Due to pancreas (body) & lungs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation autopsy - Carcinoma of Gall Bladder & metastasis to liver, body of autopsy of pancreas, lungs &

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Bachrach M.D. M. D.
Address Church Home + Hosp. Date signed Dec 2, 46

VS 180

46128 (Hospital Disposal) BALTIMORE CITY HEALTH DEPARTMENT Registered No. G46128

TN. 105995 BC# G1658

# CERTIFICATE OF DEATH 159

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 824 N. Carrollton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Baby Girl Dorsey Beverley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10th. 1946

8. AGE: Years | Months | Days: 13 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Ed Beverley
13. Birthplace Va.

MOTHER 14. Maiden Name Lucy Dorsey
15. Birthplace Va.

16 (a) Informant Baltimore City Hospital
(b) Address 4940 Eastern Ave ( Records

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 11-29-46m (month) (day) (year)
(c) [redacted] or crematory Baltimore City Hospitals
Location 4940 Eastern Ave ( Records )

18 (a) Funeral director
(b) Address

(c) -2 1946 (Date rec'd by registrar) (b) Huntington Willis [redacted]

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23rd 1946, at 4.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10th 1946 to Nov. 23 1946 and that I last saw h er alive on Nov. 23/ 1946

Immediate cause of death: Prematurity — Duration: Life

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes M. D.
Address Balto City Hosp Date signed Nov. 26 '46

VS 150

G46129

505496

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V 94a

G46129 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1300 W. University Pkway (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Nora M. Burger

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife F. Frank Burger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 2 2 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | — | — | hr. min. |

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Secretarial Work.
11. Industry or business

FATHER
12. Name Patrick McNeal
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Burley
15. Birthplace W. Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meakes and Son
(b) Address 805 N. Calvert St.

19 (a) DEC — 3 1946 (Date received by registrar) Burlington Williams, M.D.

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH Dec. 2 1946 at 5.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29 1946 to Dec. 2 1946 and that I last saw h[illegible] alive on Dec. 2 1946

Immediate cause of death Acute coronary-cardial infarction, posterior type — Duration 4 days
Due to
Due to
Other Conditions Endogenous depression — 6 yrs.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Andrew E. Salazar M. D.
Address Johns Hopkins Hosp. Date signed 2 Dec/46

VS 150

X

Dr. Jenny
Hanford to Orlando
G46130

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 93D

G46130 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2034 Edmondson Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-4
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2034 Edmondson Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George William Rommel, Sr.

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | widowed |

6 (b) Name of husband or wife Catherine T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | 10 | 0 | hr. min. |

9. Birthplace Balto. Co. Md.
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name JohnA. Rommel
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16. (a) Informant Mr. Charles Rommel
(b) Address 2704 Christopher Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/46 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Huntington Williams

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-1/46 19 , at 9:55 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1946, to Dec. 1, 1946 and that I last saw h[illegible] alive on Dec 1, 1946

| Immediate cause of death | Duration |
|---|---|
| Bronchial Pneumonia | |
| Due to Arteriosclerotic cardio-vascular disease | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathan Janney
Address 710 Harford Rd. Date signed 12/2/46 (M) (D)

VS 150
DEC -3 1946

46131 B.C. 9-6432

505459

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

C46131 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 151
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 Vincent St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Baby Girl Gray. (3).

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Black. | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-25-46.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 3 4 | hr. min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Lee Gray.
13. Birthplace Ala.

MOTHER
14. Maiden Name Willie May Dawn
15. Birthplace [illegible] La.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School DEC 3 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 3 1946 (Date rec'd by registrar) (c) [illegible] Registrar

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH Dec - 2 1946. at 3.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 28 1946. to Dec - 2 1946. and that I last saw h[illegible] alive on Dec - 2 1946.

Immediate cause of death: Prematurity (27 weeks gestation) — Duration: 3 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Demetrius D. Zuppas M. D.
Address Johns Hopkins Hospital Date signed 12-2-46

VS 150

6132 B.C.J. 69690

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

159

G46132 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Eliminion St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 202 N. Fremont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby g Frederica Lipscomb

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | Negro | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 3-4 | hr. min. |

9. Birthplace Balto. md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Levi Lipscomb
13. Birthplace Richmond Va.

MOTHER
14. Maiden Name Frederica Bland
15. Birthplace Prince George Va.

16 (a) Informant Frederica Lipscomb
(b) Address 202 N. Fremont Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Hospital School DEC 3 1946

18 (a) Funeral director Commissioner of Health
(b) Address

DEC 3 1946 Huntington Williams M. D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27-1946 at 11 46 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-23, 1946 to 11-27-1946 and that I last saw him alive on 11-27-1946.

| Immediate cause of death | Duration |
|---|---|
| Due to Premature | |
| Due to 7 months | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. [illegible] M. D.
Address 523 Druid Hill Ave Date signed 12-1-46

VS 150

46133 BC# G61231 BALTIMORE CITY HEALTH DEPARTMENT ✓ G46133 Registered No.

# CERTIFICATE OF DEATH 159

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Harlem St
(c) Hospital or institution: Provident Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 E. madison St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby of Essie Lewis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | negro | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 22 46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 12 | hr. min. |

9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Theodore Johnson
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Essie Lewis
15. Birthplace Spartanburg S.C.

16 (a) Informant Essie Lewis
(b) Address 1212 E. madison St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Hopkins Medical Schoo DEC 3 1946
18 (a) Funeral director Commissioner of Health
(b) Address
19 DEC 3 1946 (Date rec'd by registrar) (Signature) Commissioner of Health

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Nov 3 1946, at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22- 1946, to Nov- 3- 1946, and that I last saw h.i.m. alive on Nov- 3- 1946.

| Immediate cause of death | Duration |
|---|---|
| Premature birth — mt. 46 wks. | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed Nov 4 46

VS 150

6134 BC# G63053

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

G46134 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1920 Mc Cullough Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Byrd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 27, 1946

8. AGE: Years | Months | Days: 3 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Marcellus Byrd
13. Birthplace

MOTHER
14. Maiden Name: Peggy Barton
15. Birthplace: Maryland

16 (a) Informant: Hospital Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location: Johns Hopkins Medical School DEC 3 1946

18 (a) Funeral director: Commissioner of Health
(b) Address

19 DEC 3 1946 (Date rec'd by registrar) Signature of Local Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH November 30 1946, at 2:42 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 27 1946 to Nov. 30 1946 and that I last saw her alive on Nov. 30 1946

Immediate cause of death: Prematurity — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: J. Russell Jordan M. D.
Address: Johns Hopkins Hospital Date signed: 12-1-46

VS 150

016135

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. 016135

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 309 N Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 - 10
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 309 N Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles C. Wissner

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-7442

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26-1884

8. AGE: Years 62 | Months 6 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Globe Brewery

FATHER 12. Name John Wissner

13. Birthplace Germany

MOTHER 14. Maiden Name Mary Kolb

15. Birthplace Baltimore Md

16 (a) Informant Miss Labastine

(b) Address 309 N Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-46 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel

Location O'Donnell St

18 (a) Funeral director John C. Miller Inc

(b) Address 243 S Ellwood Ave

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 1946, at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1946 to Dec 1 1946, and that I last saw h[illegible] alive on Dec 1 1946.

| | Duration |
|---|---|
| Immediate cause of death: Cirrhosis Interstitial Nephritis | 3 mos |
| Due to: Arterio Sclerosis | 6 mos |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. V. Clifto

Address 5010 Greenleaf Rd Date signed 12-3-46 M. D.

VS 150

G46136
3628666

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

61

G46136
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 915 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Robert Whitehead

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | black | married |

6 (b) Name of husband or wife Rose W. Whitehead
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) 9-8-84

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 2 | 23 | hr. min. |

9. Birthplace Ga. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Graul Whitehead
13. Birthplace Ga.

MOTHER
14. Maiden Name Anna ?
15. Birthplace Ga

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Dec. 5, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Wm. Geo. H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) DEC - 3 1946 (b) [illegible] Registrar
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12-1- 1946 at 4 05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-21- 1946 to 12-1- 1946 and that I last saw h[illegible] alive on 12-1- 1946.

Immediate cause of death Cholemia — Duration 4 yr.

Due to Obstructive jaundice — 1 1/2 yr

Due to Pancreatic fibrosis

Other Conditions Diabetes Mellitus, mild, in remission.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As Above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene Turner III M. D.
Address Johns Hopkins Hosp. Date signed Dec 1 46

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G46137

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 97

Registered No. G46137

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1813 Division St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 Division St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Annie Bivens Carter

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1881

8. AGE: Years 65 | Months 4 | Days 14 | If less than one day hr. min.

9. Birthplace Sanestown, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Bivens
13. Birthplace Sanestown, Md.

MOTHER
14. Maiden Name Ida Cannon
15. Birthplace

16 (a) Informant Mrs. Idya Sheppard
(b) Address 945 N. Nicholas Ave. N

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 4, 1946 (month), (day), (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lew. H. Hall
(b) Address 1631 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 5 1946

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** ~~Dec 4~~ November 30 1946, at 2 a.m. P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from Nov. 28 1946, to ~~Dec 4~~ Nov 30 1946 and that I last saw h-- alive on ~~Dec 4~~ Nov 30 1946

| Immediate cause of death | Duration |
|---|---|
| Myocardial failure | |
| Due to Anemia | 2 hrs |
| Due to Arter. sclerosis | ? |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1725 Druid Hill Ave Date signed

V S 150

Interview Williams M.D.

X 12-3-46

G46138

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

109a

Registered No. G46138

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2451 Woodbrook Ave.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

**3 (a) FULL NAME** James Selmon Scott

3 (b) If veteran, name war

3 (c) Social Security Account No. 171-10-5130

4. Sex: male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Celia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1899

8. AGE: Years 47 | Months 5 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace Alexandria, Va
(Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER 12. Name James Scott
13. Birthplace Virginia

MOTHER 14. Maiden Name Martha ??
15. Birthplace Virginia

16 (a) Informant Celia Scott
(b) Address 2451 Woodbrook Ave.

17 (a) Burial (b) Date thereof Dec. 4, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Wm. Lyd. H. Hyllyer
(b) Address 1691 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 12/1 1946, at 5:45 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from 11/28 1946, to 12/1 1946, and that I last saw h.. alive on 12/1 1946.

| | Duration |
|---|---|
| Immediate cause of death: Atypical Pneumonia | 6 Days |
| Due to: Acute Myocarditis | 1 Day |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature Wm. L. Lloyd Berry, M. D.
Address 1420 E. Chase Date signed 12-9-46

V S 190

Huntington Hillman

G46139

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 935

G46139 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 15-19
(c) Hospital or institution: West Baltimore General Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2542 Park Heights ~~Avenue~~ Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** ISRAEL FOREMAN (Forman)

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name Mayer

13. Birthplace Russia

MOTHER 14. Maiden Name Viola

15. Birthplace Russia

16 (a) Informant Fanny Bearman

(b) Address 2542 Park Heights Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-4-46 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 1429 E Balto St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

DEC 4 1946

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3, 1946, at 1 P.M.

21. ~~I~~ certify that I took charge of the remains described above, held an inspec. & inq. thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardio-vascular Disease

Acute Pulmonary Edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Homer J. Wallace M.D. Medical Examiner.

Date signed 12-3-46

X

G46140

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G46140 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 231 N. Durham St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John LaVarre Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | Widower |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ? 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | | | hr. min. |

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Steel Worker

11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant John Lavarre
(b) Address 231 N. Durham St.

17 (a) Removal (b) Date thereof Dec. 5/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Farmville Va.

18 (a) Funeral director Mrs. Robert O. Ellis & Daughter
(b) Address 1129 N. Carlin St.

19 (a) (b) DEC 1 1946
(Date received by registrar) Registrar

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/1 1946 at 8:20 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage

Due to Arteriosclerotic C. V. Disease

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Gilbreth M.D.
Medical Examiner.
Date signed 12/6/46

Huntington Hillsman

G46141 BC# F45788 ✓ G46141

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 74a

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2832 Pelham Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2832 Pelham Avenue
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** Carol Ann Johnson

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex FE male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife. None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1942

8. AGE: Years 4 | Months 8 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Irving F Johnson
13. Birthplace [illegible] Baltimore Maryland

MOTHER
14. Maiden Name Josephine M Wild
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs Irving F Johnson
(b) Address 2832 Pelham Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-5-46 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Taylor Avenue

18 (a) Funeral director Albert L Hilt Jr
(b) Address 1606 N Chester Street

19 (a) Filed (Date received by Registrar) DEC 6 1946 (b) Registrar Huntington Williams M.D.

VS 2

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2, 1946, at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1946 to Dec 2 1946 and that I last saw h[illegible] alive on Dec 2 1946.

Immediate cause of death

Due to Acute Lymphatic Leukemia

| | Duration |
|---|---|
| | 3 mo |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work
(e) Means of injury

23. Signature H B Sloan M.D.
Address 3400 Eric Lane Date signed 12/7/46

X

G46142

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93E

Registered No. G46142

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 28-4
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 640 Stamford Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** GERHARD BOSCHEN

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| None | 213-14-3336 |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Margaret Boschen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1867

| 8. AGE: | Years | Months | Days | If less than one day |
|---|---|---|---|---|
| | 79 | 5 | 19 | hr. min. |

9. Birthplace Bremen, Germany
(Town, county, and state)
10. Usual Occupation Manager
11. Industry or business Masser Motor Express Co.

FATHER
12. Name John F. Boschen
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. John Frederick Boschen
(b) Address 640 Stamford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/5/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC - 4 1946 (b)
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2, 1946, at 2 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Congestive Cardiac Failure
Due to Congestive Edema of Lungs
Other Conditions Advanced Arteriosclerosis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mallonee M.D.
Medical Examiner.
Date signed 12-3-46

Huntington Williams
Registrar

VS 151

G46143

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 162H

Registered No. G46143

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General Hospital 14-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 a.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1524 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Mrs. Helene T. Schulz

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| -- | -- |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Carl Schulz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1897

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 49 | 0 | 7 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Schenning
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Klueck
15. Birthplace Germany

16 (a) Informant Mr. Carl Schulz
(b) Address 1524 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/46 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Pk
Location Baltimore, Maryland

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 7 1946 (Date received by Registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 3rd 19 46 at 1 P. M. 55

21. I certify that I took charge of the remains described above, held an Autopsy + Insp thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to Illuminating Gas.
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-3-46 at 12:45 P. M.
(b) Where did injury occur? 1524 Linden Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home (While at work?) no
(d) Means of injury Turned 4 burners on stove. Rubber Cover

23. Signature Howard J. Anders M.D. Medical Examiner.
Date signed 12/3/46

VS 151

G46144

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93E

Registered No. G46144

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4915 ALHAMBRA AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7 18
(e) Length of stay in Baltimore (yrs., mos., or days) 29 YR.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4915 ALHAMBRA AVE. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** HARRY MUIR MIX

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-03-4800

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | WHITE | WIDOWED |

6 (b) Name of husband or wife ANNE R. MIX
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 7 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 9 | 25 | hr. min. |

9. Birthplace NEW ALBANY, IND. (Town, county, and state)
10. Usual Occupation MACHINIST
11. Industry or business

FATHER
12. Name WILLIAM MIX
13. Birthplace ALA.

MOTHER
14. Maiden Name MARY A. JENNINGS
15. Birthplace

16 (a) Informant MR. H. L. MIX
(b) Address 4915 ALHAMBRA AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 5 '46 (month) (day) (year)
(c) Cemetery or crematory FAIRVIEW CEM.
Location NEW ALBANY IND.

18 (a) Funeral director A. R. SLADE
(b) Address 4907 YORK RD.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC - 4 1946

**MEDICAL CERTIFICATION**

20. DATE OF DEATH DEC. 2 1946 at 7:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to DEC. 2 1946 and that I last saw him alive on DEC. 1 1946

| Immediate cause of death | Duration |
|---|---|
| Myocardial Fat | 2 yrs |
| Due to | |
| Due to | |
| Other Conditions large Abdominal Hernia. (Include pregnancy within 3 months of death) | 10 yrs. |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Earl H. Benson M. D.
Address 514 York Rd Date signed DEC 4 1946

G46145

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

Registered No. G46145

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2258 Cecil Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2258 Cecil ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Jennie A. Forestell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | widowed |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 22, 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 10 | 11 | hr. min. |

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER
12. Name John T. Aro
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Matilda Stevenson
15. Birthplace Balto. Md.

16 (a) Informant John Lucker
(b) Address 2258 Cecil Ave

17 (a) Burial (b) Date thereof 12 | 5 | 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Greenmount Ave

18 (a) Funeral director Howard M. Blight Jr.
(b) Address 4914 Belair Road

19 (a) (Date rec'd by registrar) (b) Registrar

DEC - 4 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3, 1946, at 5 N P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1945 to Dec 3 1946, and that I last saw h.e alive on Dec. 3 1946

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 2 |
| Due to Sen. Arteriolenes | |
| Due to Hypertension | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Lucker

Address 1761 E. Mt. St. Date signed 12/3/46

X

G46146

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93E

Registered No. G46146

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1808 E. Federal St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 E. Federal St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** Julia Stain

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband ~~or wife~~ John E. Stain
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 6 1856

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 90 | 1 | 22 27 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Pons.
13. Birthplace Spain

MOTHER
14. Maiden Name Clivia Pons.
15. Birthplace not known.

16 (a) Informant Alice Pine
(b) Address 1203 N. Broadway.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-4-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location E. North ave.

18 (a) Funeral director Agnes A. Lutz
(b) Address 1203 N. Broadway.

19 (a) DEC - 4 1946 (Date rec'd by registrar) Monrington for William [illegible] Registrar

VS 3

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Dec. 2 1946, at 2.30 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Nov. 23 1946, to Dec 2 1946, and that I last saw h~~e~~r alive on Dec. 1 1946.

| Immediate cause of death | Duration |
|---|---|
| Myocarditis | |
| Due to | |
| Due to | |
| Other Conditions Infirmities of old age (Include pregnancy within 3 months of death) | |

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Kent Fisher M. D.
Address 1823 N. Monroe St Date signed 12/3/46

X

G46147

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93

Registered No. G46147

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2846 Raynor Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-6
(e) Length of stay in Baltimore (yrs., mos., or days) 25Yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2846 Raynor Ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lucy P. Brock

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| NO | NO |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widowed |

6 (b) Name of husband or wife William E. Brock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 0 | 22 | hr. min. |

9. Birthplace Newburn North Carolina
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name John T. Ship
13. Birthplace North Carolina

MOTHER
14. Maiden Name Jane L. ?
15. Birthplace North Carolina

16 (a) Informant Mr. Edward E. Brock
(b) Address 2846 Raynor Ave.

17 (a) Burial (b) Date thereof 12/5/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Grove
Location Newbern, North Carolina

18 (a) Funeral director Geo. W. Little
(b) Address 2700 Edmondson Ave.

19 (a) DEC - 4 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3 1946, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to Dec 3 1946 and that I last saw h[illegible] alive on Nov 2 1946.

Immediate cause of death Hypocardiak insufficiency, Arteio sclerotic Typh Heart disease with hypertension — Duration

Due to Trombu generalized arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. W. Mitchell M. D.
Address 2901 Edmondson Ave Date signed Dec 3 1946

VS 150

G46148

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46148 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave.
(c) Hospital or institution:
Maryland General Hosp. 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1Day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town 4108 Groveland Ave.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore Md.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** MERVIN M. POWERS

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | No |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Manetta G. Powers
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) July 1, 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 5 | 1 | hr. min. |

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Stone Cutter
11. Industry or business Retired

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Manetta G. Powers
(b) Address 4108 Groveland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/5/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

DEC 1 1946 (Date rec'd by registrar) (b) Thurston for Milause, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2 1946, at 11 50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1946 to 12/2 1946, and that I last saw h/M alive on 12/2 1946.

| Immediate cause of death | Duration |
|---|---|
| CEREBRAL HEMORRHAGE | 7 HRS. |
| Due to CEREBRAL ARTERIOSCLEROSIS | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles W. Stewart Jr. M. D.
Address MD. GEN. HOSP. Date signed 12/2/46

VS 150

46149

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G46149

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2425 W. Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2425 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edith J. Ihrie

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: NO

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: John Ihrie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1861

8. AGE: Years 85 | Months 5 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace St. Mary's Co.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name John W. Jones
13. Birthplace St. Mary's Co

MOTHER
14. Maiden Name Elizabeth A Wheeler
15. Birthplace ?

16 (a) Informant Mr. Paul Ihrie
(b) Address 2425 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/5/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore

18 (a) Funeral director Geo. W. Little
(b) Address 2700 Edmondson Ave.

19 (a) DEC 6 1946 (b) [illegible] Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2/46 19 at 11:30PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/20/46 19 to 12/2/46 19 and that I last saw h[illegible] alive on 12/2/46 19

Immediate cause of death: Cerebral Thrombosis — Duration: 48 hrs.
Coronary Heart Disease — Years
Due to Coronary Sclerosis — Years
Due to — Years
Other Conditions Arthritis Atrophic Senility — Years
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. J. Mandelis, M.D.
Address 651 N. Bentalou Str Date signed 12/2/46 M.D.

VS 150

B.C. B-63705

36150

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

Registered No. G36150

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Ave
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2402 Annon Court
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Tucker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Baby |

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/2/46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | 9 hr. 27 min. |

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Augustus

13. Birthplace

MOTHER
14. Maiden Name Ruth Mills

15. Birthplace Ky.

16 (a) Informant Mrs. M Tucker
(b) Address Hosp Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/46 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet
Location Balto Md.

18 (a) Funeral director Geo M Little
(b) Address 2700 Edmondson Ave.

19 DEC - 4 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2 1946, at 7:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1 1946 to 12/2 1946, and that I last saw her alive on 12/2 1946.

| Immediate cause of death | Duration |
|---|---|
| Prematurity | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address St Agnes Hospital Date signed Dec 3 46

VS 150

(over)

P.L.B. 63104

G46151

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 159

Registered No. G46151

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution:
St. Agnes Hosp. 25-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2402 Annan Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Tucker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Baby |

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/3/46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | 14 hr. 3 min. |

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business Child

FATHER
12. Name Augustus
13. Birthplace

MOTHER
14. Maiden Name Ruth Wells
15. Birthplace Va.

16 (a) Informant Mrs. E Tucker
(b) Address Hosp Reards.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto Md

18 (a) Funeral director Geo W Little
(b) Address 2700 Edmondson Ave

19 (a) DEC 4 1946 (Date rec'd by registrar) (b) Registrar's No.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2 1946, at 12:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1 1946 to 12/2 1946, and that I last saw h. alive on 12/2 1946.

| Immediate cause of death | Duration |
|---|---|
| Prematurity | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address St. Agnes Hospital Date signed Dec 3 1946

(over)

X

6152

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH ✓ 937

G46152

Reg. Dist. No.

**PLACE OF DEATH:**

(If outside city or town limits, write RURAL and give nearest town)

Is above place of death? Same.

Name of hospital, institution, or street address where death occurred: Ashburton Nursing Home

If in hospital or institution? Same!

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: County:

City or town: Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 811-10th St. N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

**FULL NAME:** Anna McCann

**3.(b) Social Security Number:**

| 4. | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | White | Single |

Name of husband or wife:

6.(c) If alive, give age: years

Date of birth (mo., day, yr.): 1869

| AGE: Years | Months | Days | If less than one day: hrs. | min. |
|---|---|---|---|---|
| 77 | | | | |

Birthplace: Maryland
(Town, county, and state)

Usual occupation: Retired

Industry or business:

Name: Unknown

Birthplace: "

Maiden name: Unknown

Birthplace: "

Informant: Mrs. Mary M. Capron

Address: 4205 Falls Road Apt. #1 Wash. D.C.

Burial, cremation, or removal. Which?

Date thereof: 12/4/46
(month) (day) (year)

Mortuary or crematory: Washington, D.C.

Place:

Funeral director: Thomas B. Hanlon

Address: 641 H St. N.E. Wash. D.C.

(Date rec'd by registrar) 19

Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Dec. 1, 1946, at 6 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1, 1946, to Dec. 1, 1946 and that I last saw h.. alive on Nov. 15, 1946

Immediate cause of death: Congestive Heart Failure — DURATION:

Due to: Arteriosclerotic C.V. Disease

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

22. SIGNATURE: Edward L. Harman, M.D.
M. D. or other

Address: 4037 Falls Rd. Date signed: 12/4/46

G46153

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 49a

Registered No. G46153

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2025 W Fayette St
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3804 Freemont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary C Kohlhepp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~: Married.

6 (b) Name of ~~husband~~ or wife: Wm V.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 14 1893

8. AGE: Years 53 | Months 1 | Days 16 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER 12. Name Thomas P. O'Hara

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Mary Hester

15. Birthplace Ireland

16 (a) Informant Wm V. Kohlhepp

(b) Address 3804 Freemont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 5 1946 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Old Frederick Road

18 (a) Funeral director John A Moran

(b) Address 3800 E Baltimore St

19 (a) (Date received by registrar) (b) Registrar

DEC 4 1946 Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/1/1946, at 3:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/15 1946 to 12/1 1946, and that I last saw h alive on 12/1 1946

| | Duration |
|---|---|
| Immediate cause of death: Respiratory Failure | 10 min |
| Due to: Pulmonary Edema | unknown |
| Due to: Hypostatic Pneumonia | 24 hrs |
| Other Conditions: Carcinomatosis Gastric Ulcer | unknown |

(Include pregnancy within 3 months of death)

Date of operation 11/23/46

Major findings of operation: Ovarian Carcinoma & General metastases

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur W. Lyons M. D.

Address Bon Secours Hosp Date signed 12/4/46

G46154

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G46154

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 128 W. Lafayette Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 128 West Lafayette Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Campbell Warfield

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Dr. MacFie Warfield
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 2 1869
8. AGE: Years 77 | Months 2 | Days 1 | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Campbell Windsor
13. Birthplace Baltimore

MOTHER
14. Maiden Name Louisa Moore
15. Birthplace Baltimore

16 (a) Informant Rebecca Warfield
(b) Address 128 West Lafayette Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 5 1946 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto Md

18 (a) Funeral director Kenny & Sanders & Sons Co
(b) Address McCulloh & Orchard Sts

19 (a) DEC 4 1946 (Date rec'd by registrar) (b) Huntington W. Berry, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1946, at 12 Noon

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946, to Dec 3 1946 and that I last saw her alive on Dec 3 1946.

Immediate cause of death: Myocarditis Arteriosclerosis — Duration: Gradual

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Hardy M. D.
Address 1403 Park Ave Date signed 12/4/46

G46155

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

G46155 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2440 E. Monument St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2440 E. Monument St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

2

3 (a) FULL NAME JOSEPH KAPLAN

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-09-6424

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Frances (nee Bolek)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1869

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 8 | 24 | hr. min. |

9. Birthplace Austria
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Joseph Kaplan
13. Birthplace Austria

MOTHER
14. Maiden Name Anna Pavlik
15. Birthplace Austria

16 (a) Informant Marie Kaplan - daughter
(b) Address 2440 E. Monument St.

17 (a) Burial (b) Date thereof 12/5/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) (b)
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

DEC 4 1946

VS 190

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 1 1946 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2 1946 to Dec. 1 1946
and that I last saw h[illegible] alive on Dec. 1 1946

| Immediate cause of death | Duration |
|---|---|
| Hypostatic Pneumonia | 1 day |
| Due to Apoplexy left side | 5 days |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm R Johnson M. D.
Address 403 Med Arts Bldg Date signed 12-3-46

G46156

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1462

Registered No. G46156

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 824 W. Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 - 3
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 824 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | white | Widowed |

6 (b) Name of husband or wife Roberta W. Fletcher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9th 1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 3 | 24 | hr. min. |

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation Contractor
11. Industry or business Steel Work

FATHER
12. Name Thomas Murphy
13. Birthplace Penna.

MOTHER
14. Maiden Name Unknown
15. Birthplace Penna.

16 (a) Informant Mrs. Mary Forth
(b) Address 824 W. Lombard St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 12/6/46 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Edmondson Ave.

18 (a) Funeral director John J. Gowan & Son
(b) Address 901-03 Hollins St.

19 (a) DEC - 4 1945 (Date rec'd by registrar) by Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3rd 1946, at 6.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1945, to 3 Dec. 1946, and that I last saw him alive on 3 Dec. 1946.

| Immediate cause of death | Duration |
|---|---|
| Carcinomatosis | 1 yr. |
| Marasmus | 2 yrs. |
| Due to Gastric Carcinoma | ? |
| Due to | |
| Other Conditions Lues. | Unknown. |
| Aortic Stenosis. (Include pregnancy within 3 months of death) | |
| Date of operation None. | |
| Major findings of operation: | |
| of autopsy: | |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Tommasello M. D.
Address 910 W. Lombard St. Date signed 4 Dec. 46.

VS 150

Tommasello ×

G46157

CWK-106538

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G46157

Registered No.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: 5-

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2Hrs. 25 Min.

(e) Length of stay in Baltimore (yrs., mos., or days) 7 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1263 E. Fayette Street
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Della Narcissus Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5-1881

8. AGE: Years 65, Months 7 ?, Days 26 ?, If less than one day ... hr. ... min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name ?

13. Birthplace

MOTHER

14. Maiden Name Pobby

15. Birthplace North Carolina

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 8, 1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cemetery

Location: Baltimore Md.

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Bentley Rd

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 4 1946

VS 150

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH December 1 19 46 at 7:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1946 to Dec. 1 19 46, and that I last saw her alive on Dec. 1 19 46

| | Duration |
|---|---|
| Immediate cause of death Aspiratory Failure: | |
| Due to Pulmonary Edema | |
| Due to Aplastic Anemia, Cause Undetermined | |
| Other Conditions Diabetes Mellitus | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: See above

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Herbert R. Faiber M. D.

Address Balto City Hosps. Date signed 12-1-46

Huntington Williams, Md

73D

6158

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 146E

Registered No. G46158

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 W Caroline St.
(c) Hospital or institution: St Joseph's Hospital 9 W 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Mo.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1531 Harford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Georgia F. Rasnake

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Billy F. Rasnake

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1923

8. AGE: Years 23 Months 7 Days 27 If less than one day hr. min.

9. Birthplace Chatham Court House Va (Town, county, and state)

10. Usual Occupation House work

11. Industry or business at Home

FATHER
12. Name Lattie Coates
13. Birthplace Va.

MOTHER
14. Maiden Name Not Known
15. Birthplace Va.

16 (a) Informant Mr. Billy F. Rasnake
(b) Address 1531 Harford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 7 1946 (month) (day) (year)
(c) Cemetery or crematory Chatham Cemetery
Location Chatham Court House Va

18 (a) Funeral director Edward F. Conklin Son
(b) Address 924 E. Eager St.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 1946

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/4/1946 at 4 22/77 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1/1946 to 12/4/1946 and that I last saw h[illegible] alive on 12/4/1946.

| Immediate cause of death | Duration |
|---|---|
| Cardio Respiratory Failure | |
| Due to (Possible Pulmonary Embolism) | |
| Due to | |
| Other Conditions Carcinoma Hepatic Flexure Colon (Include pregnancy within 3 months of death) | |

Date of operation 11/1946

Major findings of operation: Ca Hepatic Flexure Colon

of autopsy: Ileocecal Tumor left ovary

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hyman Jaworski M. D.
Address 1 W Mo. Lloyd Date signed 12/4/46

46159 405832

BALTIMORE CITY HEALTH DEPARTMENT X

# CERTIFICATE OF DEATH 46B

Registered No. G46159

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State W. Va. (b) County.....
(c) City or town Parkersburg (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 33rd St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No) If yes, name country.....

**3 (a) FULL NAME** Baumgardner, Agra Mae

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | M |

6 (b) Name of husband or wife Baumgardner J.
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 2-15-98

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 48 | 9 | 19 | ..... hr. ..... min. |

9. Birthplace W. Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Wm. Wade
13. Birthplace W. Va.

MOTHER 14. Maiden Name Lenore Riddle
15. Birthplace W. Va.

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12/4/46 (month) (day) (year)
(c) Cemetery or crematory Evergreen
Location Parkersburg W Va

18 (a) Funeral director Harry H Wilke
(b) Address 4161 Edmondson Ave

19 [illegible] (b) Filed [illegible] Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4 December 1946, at 12:00 N

21. I certify that death occurred on the date above stated; that I attended deceased from 11-26 1946, to 12-4 1946, and that I last saw her alive on 12-4 1946

Immediate cause of death Inanition — Duration

Due to Carcinoma of Stomach

Due to.....

Other Conditions Late Syphilis Bronchopneumonia
(Include pregnancy within 3 months of death)

Date of operation 2-December 46

Major findings of operation: Extensive Carcinoma

of autopsy:.....

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... (Specify type of place) While at work?.....
(e) Means of injury.....

23. Signature Richard D. Bush M. D.
Address Johns Hopkins Hosp Date signed 12-5-46

VS 150

G46160 • BALTIMORE CITY HEALTH DEPARTMENT G46160

# CERTIFICATE OF DEATH 1932

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1933 Hollins St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-3
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1933 Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Harry A Kapp

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 23 1879

8. AGE: Years 66 | Months 11 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business

FATHER
12. Name Samuel F Kapp
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Jenny McCommon
15. Birthplace Baltimore Md

16 (a) Informant Mrs F Kapp
(b) Address 1933 Hollins St

17 (a) London Park (Burial, cremation, or removal) (b) Date thereof Dec 6-46 (month) (day) (year)
(c) Cemetery Burial
Location Frederick Road Inc

18 (a) Funeral director Wilson Co Inc
(b) Address 1217 E Fort Ave

19 (a) Dec 5 - 1946 (Date rec'd by registrar) Huntington Williams Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 3 1946, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3 1946 to Dec 3 1946 and that I last saw h[illegible] alive on Dec 3 1946.

Immediate cause of death: Acute Myocardial Infarction — Duration: Few Hours

Due to: Chronic Asthma

Due to: Asthma

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter D Thomas
Address 502 Edmondson Date signed 12/4/46

VS 150

G46161

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46161 Registered No. 1113

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2737 Maryland Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2737 Maryland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Dr Frank Diehl

3 (b) If veteran, name war 10

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~ |
|---|---|---|
| M | W | Widowed |

6 (b) Name of ~~husband or wife~~ Daisy Vivian Diehl

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | | | hr. min. |

9. Birthplace Unknown
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Police Report
(b) Address City Hall

17 (a) Burial (b) Date thereof 12/7/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mayland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (b)
(Date received by registrar) Registrar

DEC 5

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**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec 2 1946, at 11:20 P M

**21.** I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William S. Gerber M.D.
Medical Examiner.
Date signed Dec 3, 1946

G46162
CWK-106261

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 1 12

Registered No. G46162

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 63- 1- 8-

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1221 Holbrook Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** George Dillman

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Mae Dillman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25-1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 1 | 8 9 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Maintenance Man
11. Industry or business City of Balto

FATHER
12. Name Jacob Dillman (D)
13. Birthplace Germany

MOTHER
14. Maiden Name Rosina Suess (D)
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Balto. Md.
18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.
19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH Dec. 3-1946 19..., at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21 1946, to Dec. 3 1946, and that I last saw him alive on Dec. 3 1946.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Tuberculosis, Far-advanced | 50 yrs |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. J. Hynd M. D.
Address Balto. City Hosp. Date signed 12-3-46

VS 150 DEC 5 - 1946

G46163

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46163 / 1102

Registered No. G46163

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 54 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 23 West St. (If rural give location)
(e) Citizen of foreign country? YES (Yes or No)
If yes, name country Phillipine Islands

**3 (a) FULL NAME** Malasarte, Delmacio

3 (b) If veteran, name war:
3 (c) Social Security Account No. 133-01-7545

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16, 1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 8 | 18 | hr. min. |

9. Birthplace: Masbata, PI (Town, county, and state)
10. Usual Occupation: Cook
11. Industry or business: Seafarer

FATHER
12. Name: Mamerto Malasarte
13. Birthplace: PI

MOTHER
14. Maiden Name: Christina ?
15. Birthplace: PI

16 (a) Informant: Records
(b) Address: US Marine Hospital, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 7-46 (month) (day) (year)
(c) Cemetery or crematory: Harmans Presbyterian
Location: Balto. Md.

18 (a) Funeral director: Ellsworth Armistead
(b) Address: 3911 Liberty Heights Ave

19 (a) Dec 5 1946 (Date rec'd by registrar) Hunting & Williams

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 4 1946, at 10:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 11 1946 to Dec. 4 1946 and that I last saw him alive on Dec. 4 1946

| Immediate cause of death | Duration |
|---|---|
| (1) Atelectasis bilateral, massive | 48 hrs. |
| (2) Effusion pleural, massive | 48 hrs. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 11/12/46 & 12/2/46
Major findings of operation: --
"Thoracolumbar sympathectomy"
of autopsy: As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 12/4/46

VS 150

G46164

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G46164 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address MONUMENT ST
(c) Hospital or institution: SINAI HOSPT
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 N. MADEIRA ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CELIA SAUNDERS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | W |

6 (b) Name of husband or wife WALTER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 | | | hr. min. |

9. Birthplace BALTO MD
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name HARRIS
13. Birthplace RUSSIA

MOTHER
14. Maiden Name LENY
15. Birthplace RUSSIA

16 (a) Informant HOSPT RECORDS
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-6-46 (month) (day) (year)
(c) Cemetery or crematory HERRING RUN
Location Phila Rd + Bowleys Lane

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St

19 (a) [illegible] (Delivered by Registrar) (b) Huntington Williams Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-4 1946, at 1.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-4 1946, to 12-4 1946, and that I last saw her alive on 12-4 1946.

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan B. Hymanson M. D.
Address Sinai Hospital Date signed 12-4-46

VS 150

G46165

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

Registered G46165

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 434 E 20th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 434 E. 20th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Francis Henry Davis

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29-1864

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 11 | 15 | hr. min. |

9. Birthplace ? (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs Nora T. Stull
(b) Address 434 E. 20th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec-7-1946 (month) (day) (year)
(c) Cemetery or crematory Lloyd Town Cem.
Location Lloyd Town Md.

18 (a) Funeral director Joseph Tavares Inc.
(b) Address 20 B Monument Ave

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 5

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/4/1946, at 6a M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1/1946, to 12/4/1946, and that I last saw h alive on 19

| Immediate cause of death | Duration |
|---|---|
| Coronary Occlusion | 2 hours |
| Due to Coronary Sclerosis | 6 mos |
| Due to Arteriosclerosis | 1 year |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas F. Mills
Address 532 E 22nd St. Date signed 12/4/46 M D

X

G46166 — AB-106164

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1313

G46166 — Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 19-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 South Stricker Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** George Charles Brown

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | White | Divorced |

6 (b) Name of husband or wife Katherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 15- 1902

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 44 | 1 | 15 | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George G. Brown
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Warren
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/5/46 (month) (day) (year)
(c) Cemetery or crematory Laurel Heights
Location Lexington & L.R.R.

18 (a) Funeral director Jay J. Lahey
(b) Address 1316 Eutaw St.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 5 - 1946

**MEDICAL CERTIFICATION**

20. DATE OF DEATH November 30 1946, at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-17- 1946 to 11-30 1946 and that I last saw him alive on 11-30- 1946

| | Duration |
|---|---|
| Immediate cause of death Pulmonary Tuberculosis, far advanced | 4 yrs. |
| Due to | |
| Due to | |
| Other Conditions Chronic Heart Disease (Include pregnancy within 3 months of death) | 28 years |

Date of operation
Major findings of operation:
of autopsy: Same

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm J. Hunt M. D.
Address Balt. City Hosp. Date signed 12-3-46

Huntington Williams, M.D.

CWK-106595 G46167

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G46167

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 17-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2Hrs-10 Min
(e) Length of stay in Baltimore (yrs., mos., or days) 21 Yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 689 Pierce Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Pearl Woodward

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | Widowed |

6 (b) Name of husband or wife Julius (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25-1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 8 | 9 10 | hr. min. |

9. Birthplace South Carolina
(Town, county, and state)
10. Usual Occupation House Work
11. Industry or business

FATHER
12. Name Nathan Montgomery
13. Birthplace South Carolina

MOTHER
14. Maiden Name Nancy Williamson
15. Birthplace South Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 12 - 6 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Milligan & Jackson
(b) Address 916 Pennsylvania ave

19 (a) DEC 5 1946
(Date rec'd by registrar) Registrar

VS 150

Huntington Williams, M.D.

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH December 8 (4) 1946 3:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 4 19 46 to Dec. 4 19 46, and that I last saw h er alive on Dec. 4 19 46.

| Immediate cause of death | Duration |
|---|---|
| Respiratory Failure | |
| Due to Cerebral Hemorrhage | |
| Due to | |
| Other Conditions Hypertensive Cardio Vascular Disease | |
| (Include pregnancy within 3 months of death) | |
| Date of operation | |
| Major findings of operation: | |
| of autopsy: same as above | |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. Earhardt, M.D.
M. D.
Address Balto. City Hosp. Date signed 12-7-46

X

G16168

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G16168

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Oaklee Village Apt 36
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Oaklee Village - Apt. 36
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELMER G. KRUEGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mabel Claire Krueger (nee Taylor)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27, 1893

8. AGE: Years 53 | Months 10 | Days 6 | If less than one day hr. min.

9. Birthplace Burlington, Iowa
(Town, county, and state)

10. Usual Occupation Social Security

11. Industry or business

FATHER
12. Name - Krueger
13. Birthplace Burlington

MOTHER
14. Maiden Name -
15. Birthplace -

16 (a) Informant Mrs. Mabel Claire Krueger
(b) Address Oaklee Village, Apt. 36

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/5/46 (month) (day) (year)

(c) Cemetery or crematory
Location Burlington, Iowa

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/3/46 19 , at 8:00 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Dawson M.D.
Medical Examiner.
Date signed 12/4/46

G46169 BALTIMORE CITY HEALTH DEPARTMENT G46169
CERTIFICATE OF DEATH 1937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2712 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2712 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN A. LINSENMEYER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Sophie K. Linsenmeyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1867

8. AGE: Years 79 | Months 7 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Linsenmeyer
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Bauerline
15. Birthplace Germany

16 (a) Informant Mr. Frederick Linsenmeyer
(b) Address 2712 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4, 1946, at 2:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 25 1946 to Dec 4 1946 and that I last saw h[illegible] alive on Dec 3 1946

Immediate cause of death: Chronic cardio vascular disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ernest W. Rabin

Address 1735 Bolton St Date signed 12/4/46 (M. D.)

V S 150

G46170 G46170

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 1315

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3105 Wallbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grover Robert Cochran

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | single |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1937

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 9 | 4 | 17 18 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation schoolboy
11. Industry or business

FATHER
12. Name Robert J. Cochran
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Lucille Keller
15. Birthplace Balto. Md.

16 (a) Informant Robert J. Cochran
(b) Address 3105 Wallbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-5-46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3707 W. North Ave.

19 (a) DEC 5 (Date rec'd by registrar) (b) Huntington Wills Registrar, M. D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-5 1946 at 9:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-28 1946 to 12-5 1946 and that I last saw him alive on 12-5 1946

Immediate cause of death Respiratory failure - Pulmonary oedema — Duration

Due to Uremia - Anuria

Due to Acute Glomerular Nephritis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation

of autopsy Kidneys of Nephritic Type

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F. C. Hallenberger Jr. M. D.
Address University Hospital Date signed 12-7-46

VS 150

G46171
JL - 106525

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 13B

G46171
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mo 17 days (18 days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 E. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Satchell

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | Widowed |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible] 1899

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| (46) 47 | 11 | 2 | hr. min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Douglass
13. Birthplace Va.

MOTHER
14. Maiden Name Eliz. Jenkins
15. Birthplace N. J.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County, Md.

18 (a) Funeral director Joseph L. Locke, Jr.
(b) Address 3/30 N. Central Ave

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 3, 1946, at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1946 to Dec. 3 1946, and that I last saw him alive on Dec. 3 1946.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Tuberculosis, Far Advanced | UNKNOWN |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy: Same

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph L. Bird M. D.
Address Balto City Hosps Date signed 12-4-46

VS 110 DEC 5 - 1946 Huntington Williams, M.D.

G46172

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 93D

G46172 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2814 Dillon St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town 2814 Dillon St. Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pelagia Cwiklinski or Tillie Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband ~~or wife~~ Andrew
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 5, 1892
8. AGE: Years 53 | Months 11 | Days 29 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Michael Rozyk
13. Birthplace Poland

MOTHER
14. Maiden Name Antonina Wojtaszek
15. Birthplace Poland

16 (a) Informant Antonette Curklinski
(b) Address 2814 Dillon Street
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Avenue
18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson Street
19 (a) (Date received by registrar) Huntington Ave Williamsport Md. (Registrar)

DEC 5

VS 181

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/3/46 19 at 1:10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Atherosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 12/4/46

X

G46173

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1149a

G46173 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr 55 min
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 S. Bethel St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mc Cann, Agnes G64346

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mc Cann, Howard

6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) January 1918

8. AGE: Years 28 | Months 10 11 | Days | If less than one day ..... hr. ..... min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Kovalchik, ?
13. Birthplace ?

MOTHER
14. Maiden Name ?, Victoria
15. Birthplace ?

16 (a) Informant Husband - Howard Mc Cann
(b) Address 410 S. Bethel St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/7/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location Duryea, Penna.

18 (a) Funeral director W. F. Radowski Sons
(b) Address 1308 Eastern Ave

19 (a) DEC 5 (Date received by Registrar) (b) 1946 Huntington Millers

VS 5

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 3, 1946, at 4:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-3- 1946, to 12-3- 1946, and that I last saw her alive on 12-3- 1946.

| Immediate cause of death | Duration |
|---|---|
| Post partum shock | 1 hr 55 min |
| Due to Inversion of uterus | 1 week |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard J. Tortman M. D.
Address Date signed

X

G46174

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93E

Registered No. G46174

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3529 Oakmont Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore City,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3529 Oakmont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John T. O'Brien

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | widower |

6 (b) Name of husband or wife Anna O'Brien
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13, 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 8 | 21 | hr. min. |

9. Birthplace Chambersburg, Pa.
(Town, county, and state)
10. Usual Occupation Plumber,
11. Industry or business --

FATHER
12. Name John T. O'Brien,
13. Birthplace New York City,

MOTHER
14. Maiden Name Barbara Strohaver,
15. Birthplace Westminister, Md.

16 (a) Informant Mrs. John T. Langmead,
(b) Address 3529 Oakmont Ave.

17 (a) Burial (b) Date thereof 12/7/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral,
Location Baltimore City,

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) (b)
(Date rec'd by registrar)

VS-180 DEC 5 - 1946 Huntington Hill Boulevard

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec. 4 1946, at 7.30 A. M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Nov 20 1946 to 12/4 1946, and that I last saw him alive on 12/3 1946

Immediate cause of death: (a) Myocardites — Duration 15 Days
Due to: (b) intoxem
Due to: (c) Senility
Other Conditions: —

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide? no
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury:

23. Signature Thomas J. Mills M. D.
Address 5276 Park Heights Ave Date signed Dec 4 46

X

G46175

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1108

G46175 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2200 Druid Hill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 - 3 none
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2200 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred Walker ✓

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: unknown
4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: M
6 (b) Name of husband or wife: Annabelle
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 2/19/1887
8. AGE: Years 59 | Months 9 | Days 14 | If less than one day hr. min.
9. Birthplace Painter (town, county, and state) South Carolina
10. Usual Occupation
11. Industry or business

FATHER
12. Name Alex Walker
13. Birthplace S. C.

MOTHER
14. Maiden Name Martha Kelsey
15. Birthplace S. C.

16 (a) Informant John H. Walker
(b) Address 2200 Druid Hill Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.
18 (a) Funeral director Wm. H. Kelson
(b) Address 1303 Preastman St
19 (a) (Date rec'd by registrar) (b) Registrar

REC 5 - 1946 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12-3 1946 at 7A M
21. I certify that death occurred on the date above stated; that I attended deceased from 11-20 1946 to 12/3 1946 and that I last saw h. alive on 12/2 1946

Immediate cause of death: Lobar Pneum

| | Duration |
|---|---|
| Due to | 12 Dy |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible]
Address 1115 Pine St Date signed 12/4/46 M.D.

X

G46176

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 50

G46176
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3816 8th ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) 14

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3816 8th St - Brooklyn (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta Riggin.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Horace Riggin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14 1879

8. AGE: Years 67 | Months 6 | Days 19 | If less than one day hr. min.

9. Birthplace Crisfield Somerset Co Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business None

FATHER
12. Name Henry Hardester
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Alice Rowe
15. Birthplace W. Moreland Co. Va

16 (a) Informant Mr Riggin
(b) Address 3816 8th St. Brooklyn Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/5 (month) (day) (year)
(c) Cemetery or crematory Sunny Ridge
Location Crisfield, Md

18 (a) Funeral director Howard H. Hubbard
(b) Address Crisfield, Md.

19 (a) (Date rec'd by registrar) (b) By Whitt

VS 150 DEC 5 - 1946 Huntington Williams

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1946 at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1-46 19 , to 12-3-46 19 , and that I last saw h[illegible] alive on 12-3-46 19

Immediate cause of death Terminal bronchopneumonia — Duration 2 days

Due to Metastatic carcinoma of prostate and lymphangitis of

Due to Carcinoma of left lung

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P. S. Bruce M.D.

Address 641 Wash Blvd Date signed 12-4-46

X

G46177

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G46177 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 310 W. Schroeder St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 D
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 310 W. Schroeder St. (If rural give location)
(e) Citizen of foreign country? ha (Yes or No)
If yes, name country

**3 (a) FULL NAME** Eliza Dryden

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Femal | Col. | Widow |

6 (b) Name of husband or wife John Dryden
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 3 | | hr. min. |

9. Birthplace South River Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Cromwell
13. Birthplace Md.

MOTHER
14. Maiden Name Maria Hall
15. Birthplace Md.

16 (a) Informant Thomas Watkins
(b) Address 915 Jst N.W. Wash. D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 5 1946 (month) (day) (year)
(c) Cemetery or crematory Brewer Hill Cem.
Location Annapolis Md.

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 822 W. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 2 1946 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 21 1946 to Dec 2 1946 and that I last saw h alive on Dec 2 1946.

| Immediate cause of death | Duration |
|---|---|
| Cardiac Vascular | |
| Shock | 2 yrs |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. D. Wars M. D.
Address 5152 Ashbourne Date signed 12/4/46

V S 150 DEC 5 - 1946 Huntington Williams

X

G46178 BC# 50280 BALTIMORE CITY HEALTH DEPARTMENT G46178

# CERTIFICATE OF DEATH

Registered No. 107

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address [illegible]
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits write RURAL and give town)
(d) Street No. 1215-A Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth McNeil

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1946

8. AGE: Years | Months 5 | Days 5 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

MOTHER'S FATHER'S

12. Name Lee C. McNeil
13. Birthplace N.C.

14. Maiden Name Christine Craven
15. Birthplace Greensboro N.C.

16 (a) Informant Christine C. McNeil
(b) Address 1215 E. Lexington St

17 (a) Burial (b) Date thereof Dec 7 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 3 1946, at 8:35 M

21. I certify that I took charge of the remains described above, held an Autopsy & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Broncho-Pneumonia

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William L. Pelbach M.D.
Medical Examiner.
Date signed Dec 3-1946

Hunting for Williams M.D.

G16179

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V30E

Registered No. G16179

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert and Saratoga Streets
(c) Hospital or institution: Mercy Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 2da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 916 Carey Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Elsie White

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1895

8. AGE: Years 51 | Months 4 | Days 17,4 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Laundress

11. Industry or business —

FATHER
12. Name Richard White
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Anna Edwards
15. Birthplace Baltimore, Maryland

16 (a) Informant James Jordan M.D.
(b) Address Mercy Hospital, Baltimore

17 (a) Burial (b) Date thereof Dec. 7 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Laurel Cem
Location —

18 (a) Funeral director Wm. Foster R. Williams
(b) Address 3209 W. Lanvale St

19 (a) ..... (b) .....
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2 Dec 1946 at 7:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 31 Oct 1946 to 16 Nov 1946.
and that I last saw h.R.? alive on 2 Dec 1946.

Immediate cause of death (a) Pulmonary t
Cardiac failure

Due to (b) Chronic Heart disease &
Cerebral hemorrhage, failure, etc.

Due to (c) —

Other Conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation —

of autopsy None

| Duration |
|---|
| |
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature James Jordan M.D.
Address Mercy Hospital, Balt Date signed 3 Dec 1946

WS 150 5-1946 Huntington Williams, M.D.

G46180

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 194a

G46180 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2003 Walbrook Ave.
(c) Hospital or institution:
15-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 Walbrook Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Leo J. Fogerty

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-01-1294

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Mattie Irene Fogerty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9 1899

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 47 | 5 | 24 25 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Night Watchman
11. Industry or business Stewart & Co

FATHER
12. Name James J. Fogerty
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Frances Rock
15. Birthplace Baltimore Md

16 (a) Informant Mattie Irene Fogerty
(b) Address 2003 Walbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 7 1946 (month) (day) (year)
(c) Cemetery or crematory Most Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Harry P. Shumaker
(b) Address 4204 Ridgewood Ave

19 (a) DEC 5 1946 (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 4 1946 at 6.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3 1946 to Dec 4 1946. and that I last saw him alive on Dec 4 1946.

Immediate cause of death Coronary Thrombosis — Duration 1 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Ashman M.D.
Address 19210 Hunt Cove Date signed 12/5/46 M. D.

VS 150

Huntington Hall

X

G46181 BALTIMORE CITY HEALTH DEPARTMENT G46181
CERTIFICATE OF DEATH 94a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 N.Hilton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-8
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Windsor Court Apts J 3 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Christine Helena Godwin

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William S.Godwin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8 1888

8. AGE: Years 58 | Months 4 | Days 27 | If less than one day: 28 hr. min.

9. Birthplace Brooklyn N.Y. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Keller
15. Birthplace Germany

16 (a) Informant William S.Godwin
(b) Address Windsor Court Apts J 3

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Dec 7 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Harry F. Comes
(b) Address 4204 Ridgewood Ave

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams M.D.

DEC 9 - 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5 1946 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to Dec 5 1946 and that I last saw her alive on Dec 4 1946

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | |
| Due to Cerebral Hemorrhage | |
| Due to | |
| Other Conditions Arterio-sclerosis | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bernard T. French M.D.
Address 7327 Greenwich Date signed 12/5/46

G16182

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93E

Registered No. 3698

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1002 Edmonson Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 164
(e) Length of stay in Baltimore (yrs., mos., or days) 25yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 Edmonson Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Stewart A. Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Mrs Susan Lewis

6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) 2-15-1858

8. AGE: Years 88 | Months 9 | Days 17 | If less than one day hr. min.

9. Birthplace Lewisburg W. Va (Town, county, and state)

10. Usual Occupation Minister

11. Industry or business M.E.

FATHER
12. Name Charles Lewis
13. Birthplace W. Va.

MOTHER
14. Maiden Name Martha T. Lewis
15. Birthplace W. Va.

16 (a) Informant Susan P. Lewis
(b) Address 1002 Edmonson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/5/46 (month) (day) (year)
(c) Cemetery or crematory Arlington Mem Pk
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Brantley Ave

19 (a) [illegible] (Date rec'd by registrar) 1946 Huntington W. Va. (Signature of registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-2-1946 at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-1943 to 12-2-1946 and that I last saw him alive on 12-1-1946.

| Immediate cause of death | Duration |
|---|---|
| Myocarditis | 5 years |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank A Saunders M. D.
Address 1029 N. Stricker St Date signed 12-7-46

VS 150

G46183

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13B

G46183 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 713 Denison Street
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 Denison Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Nellie Margaret Curtis

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife late James D. Curtis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 12, 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 9 | 21 | hr. min. |

9. Birthplace Ohio
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Tubal Cane Simon
13. Birthplace Ohio

MOTHER
14. Maiden Name Elizabeth Harris
15. Birthplace Ohio

16 (a) Informant Miss Mary J. Curtis
(b) Address 713 Denison Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Road

18 (a) Funeral director Harry H. Mitzke
(b) Address 4101 Edmondson Avenue

19 (a) (b)

DEC 5 1946 Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 3, 1946, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 29, 1944 to Dec. 3, 1946, and that I last saw her alive on Dec. 2, 1946

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure | 6 mos. |
| Due to Pulmonary tuberculosis | 10 Yrs. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dwight A. Kemp M. D.
Address 3030 Edmondson Avenue Date signed 12/4/46

X

G46184

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1318

Registered No. G46184

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3515 W. Garrison Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mo 18
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3515 W. Garrison Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Caroline E. Kennedy

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Richard D. Kennedy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23 1888

8. AGE: Years 58 | Months 2 | Days 11 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Henry Monroe Yeatman
13. Birthplace Richmond Va.
MOTHER 14. Maiden Name Georgeanna Chilcott
15. Birthplace Balto Md

16 (a) Informant Mr. Richard D. Kennedy
(b) Address 3515 W. Garrison Blvd

17 (a) Burial (b) Date thereof 12-6-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.
18 (a) Funeral director Leon Byers
(b) Address 500 Park Ave Huntington Williams, Md.
19 (a) DEC 5 - 1946 (b)
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 4 1946 at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 15 1946 to Dec 4 1946, and that I last saw h[illegible] alive on Dec. 3 1946.

| Immediate cause of death | Duration |
|---|---|
| Rheumatic Heart Disease & Decompensation | 4 years |
| Due to | |
| Due to | |
| Other Conditions Chr. Glomerular Nephritis. (Include pregnancy within 3 months of death) | Indefinite |

Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathaniel M Beck M. D.
Address 100 E. 23rd St Date signed Dec 5 46

VS 150

95 B

G46185

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

108

G46185 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 644 Washington Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 644 Washington Boulevard
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME DORY [redacted] W. BOONE

(b) If veteran, name war

3 (c) Social Security Account No. 216-01-9739

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: DIVORCED

(b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1887

8. AGE: Years 59 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace JOHNSVILLE, MD.
(Town, county, and state)

10. Usual Occupation HARDWOOD FINISHER

11. Industry or business

12. Name EMORY S. BOONE

13. Birthplace JOHNSVILLE MD.

14. Maiden Name MARY ALICE FOGLE

15. Birthplace JOHNSVILLE, MD.

16. (a) Informant DANIEL FRITZE

(b) Address 644 WASHINGTON BLVD.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-46 (month) (day) (year)

(c) Cemetery or crematory BEVER DAM CEM.

Location Near Union Bridge Md

18. (a) Funeral director Cashour, Inc.

(b) Address 414 N. Franklintown Rd. Baltimore, Md.

19. (a) (Date received by registrar) DEC 5 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3, 1946, at 11.15 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Left cerebellar hemorrhage

Due to { Lobar pneumonia, right lower lobe
Hypertrophy of heart
Fat infiltration of liver

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury [redacted] at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12-4-46

VS 191

X

G46186

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1946

G46186 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkins Ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore Md Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 S. Rolling Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Norman Lingenfelter

3 (b) If veteran, name war: World War
3 (c) Social Security Account No. 212-07-6203

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Thelma Gertrude Lingenfelter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1898

8. AGE: Years 48 | Months — | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace Ella, Md. (Town, county, and state)

10. Usual Occupation Engineer
11. Industry or business Gas & Electric Co.

12. Name Samuel F. Lingenfelter
13. Birthplace Ella, Md

14. Maiden Name Jane Elizabeth Tuckey
15. Birthplace Albenton, Md.

16 (a) Informant Norman O. Lingenfelter Jr
(b) Address 206 S. Rolling Rd. Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 6, 1946 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cem.
Location Woodlawn, Md.

18 (a) Funeral director Easton Sons
(b) Address 608 Frederick Ave Catonsville

19 (a) ____ (Date rec'd by registrar) (b) Huntington Williams Md

DEC 5 - 1946

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/4 1946, at 3:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to h.s death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH •
Coronary Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 12/4/46

X

G46187

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

131B

Registration No. G46187

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 132 N. Randall St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 132 N. Randall St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

**3 (a) FULL NAME** Louise (Louisa) Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Reuben D. Smith
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Nov. 18, 1873

8. AGE: Years 73 | Months — | Days 16 | If less than one day: hr. min.

9. Birthplace: Balto., Md. (State, county, and state)
10. Usual Occupation: At Home
11. Industry or business

FATHER
12. Name: Bartlett Albert
13. Birthplace: Germany —

MOTHER
14. Maiden Name: Catherine Miller
15. Birthplace: Germany —

16 (a) Informant: Miss Ruth M. Smith (Daughter)
(b) Address: 132 W. Randall St., Balto. 30, Md.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof: Dec. 7, 1946 (month) (day) (year)
(c) Cemetery or crematory: Western Cem.
Location: Balto., Md.

18 (a) Funeral director: A. Raymond Evans
(b) Address: 1400 S. Charles St., Balto. 30, Md.

19 (a) Dec 5 1946 (Date rec'd by registrar) (b) Huntington Station, N.Y.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 4, 1946, at 1:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 3, 1946, to Dec 4 1946 and that I last saw h[illegible] alive on Dec. 2 1946.

| | Duration |
|---|---|
| Immediate cause of death: Secondary Anaemia following Acute and Chronic Hemorrhage | 6 Mo |
| Due to: Massive Chronic Ulceration of Skin of Right Leg. | 2 Yrs |
| Due to: Extensive 3rd degree Burns in Childhood | 63 Yrs |
| Other Conditions: Chronic Nephritis | Unknown |

(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: James R. Peterman, M. D.
Address: 1216 Hanover St. Date signed: 12/5/46

16188

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. C16188

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 Park Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES W. McCOY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: ~~White~~ Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lillie Farner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1874

8. AGE: Years 72 | Months 1 | Days 22 | If less than one day ....hr. ....min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

12. Name —

13. Birthplace —

14. Maiden Name —

15. Birthplace —

16 (a) Informant Mrs. Lillie F. McCoy

(b) Address 2 Meadow St. Brandford, Conn.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/46 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial

Location Arbutus, Md.

18 (a) Funeral director John O. Mitchell Sons

(b) Address 1900 Eutaw Place

19 (a) DEC 5 — 1946 (Date rec'd by registrar) Huntington Williams Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 2, 1946, at 10.30 A M

21. I certify that I took charge of the remains described above, held an inspec. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Amos J. Mercurio M.D.
Medical Examiner.

Date signed 12-2-46

VS 191

16189

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46D

Registered No. G46189

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2520 E Preston St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2520 E Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martin P. Barnes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Anna A. Barnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14 - 1876

8. AGE: Years 70 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Michael Barnes
13. Birthplace Ireland

MOTHER 14. Maiden Name Margaret Kennedy
15. Birthplace Ireland

16 (a) Informant Anna A. Barnes
(b) Address 2520 E Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 6-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director John J. Gilligan
(b) Address 3000 E. Baltimore St.

19 (a) (Entered by Registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1946 at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 23 1946, to Dec 3 1946, and that I last saw him alive on Dec 2 1946.

| | Duration |
|---|---|
| Immediate cause of death: Carcinomatosis, generalized | ? |
| Due to: Carcinoma of rectum | 2 yrs |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)
Date of operation Aug 1945
Major findings of operation: Carcinoma of rectum
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Martin P. Barnes M. D.
Address 1109 St Paul St Date signed Dec 3 1946

VS 150

46190 BALTIMORE CITY HEALTH DEPARTMENT G46190

# CERTIFICATE OF DEATH 1937

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division ST
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1402 Druid Hill
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lewis T. Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | N | Widowed |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | | | hr. min. |

9. Birthplace Fredrick Md
(Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business Public Service

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Margaret Goodwin

15. Birthplace Frederick, Md

16 (a) Informant Mrs Maudice Rideout

(b) Address 168 - Glenburnie, Md

17 (a) V (Burial, cremation, or removal) (b) Date thereof 12-8-46 (month) (day) (year)

(c) Cemetery or crematory Orbitus Mem Park

Location Baltimore Co.

18 (a) Funeral director Mr Leo W. Holland

(b) Address 1631 Druid Hill Ave

19 (a) DEC 5 - 1946 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-4 1946, at 3:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1 1946 to 12-4 1946, and that I last saw him alive on 12-4 1946

Immediate cause of death: Cardio-Vascular disease (Congestive Heart Failure) — Duration

Due to Rheumatic Heart Disease

Due to Rheumatic Fever

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. A. S. Jackson / D. Clinton M. D.

Address 1514 Division ST Date signed 12-5-46
Baltimore, Md

G46191

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G46191

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) unknown

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 17 No. Ellamont St. Balto 22 (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

**3 (a) FULL NAME** ~~Otis~~ Otis Lee Estep

3 (b) If veteran, name war None

3 (c) Social Security Account No. 217-20-2195

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | |

6 (b) Name of husband or wife Anne Estep
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 13 (1887) 1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 57 | 9 | 21 | hr. min. |

9. Birthplace Masonico Virginia (Town, county, and state)
10. Usual Occupation Retired guard
11. Industry or business Police Dept

FATHER
12. Name William Estep
13. Birthplace Virginia

MOTHER
14. Maiden Name Clara Klein
15. Birthplace Virginia

16 (a) Informant Mrs. Anna Estep
(b) Address 17 No Ellamont St. Balto 22

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 7, 1946 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Howard County, Md.

18 (a) Funeral director George L'Echevel
(b) Address 2101 Frederick Ave.

19 (a) (Date rec'd by registrar) (b) Washington Williamsburg

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4 1946, at 6 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1946 to Dec 4 1946, and that I last saw h[illegible] alive on Dec 2 1946.

Immediate cause of death: Coronary artery thrombosis — Duration: Hours

Due to:

Due to:

Other Conditions Bronchopneumonia

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George H. Yeatman M.D.
Address UMH Date signed 12/9/46

VS 150

G46192

AB-106565

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 51 B

Registered No. G46192

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 217 S. Bentalou Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles Hartman

**3 (b) If veteran, name war**

**3 (c) Social Security Account No.**

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Alice May Foley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 11- 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 3 | 24 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Charles Hartman
13. Birthplace Maryland

MOTHER
14. Maiden Name Ophelia Foley
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12-7-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director Leroy L. Schwartz
(b) Address 2101 Frederick Ave.

19 (a) I Wife (b) Huntington Williams M.D.
(Duty of Informant) Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** December 5- 1946, at 8.45 AM

**21.** I certify that death occurred on the date above stated; that I attended deceased from 12-2- 1946 to 12-5- 1946 and that I last saw h im alive on 12-5-46 1946

| Immediate cause of death | Duration |
|---|---|
| Cardiac Failure | |
| Due to Arteriosclerotic Heart Disease | |
| Due to | |
| Other Conditions Carcinoma of Prostate (Include pregnancy within 3 months of death) | 2 years |

Date of operation
Major findings of operation:
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature J. C. Robinson Jr. M. D.
Address Balt City Hosp Date signed 12/5/46

VS 150

G46193

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

Registered No. G46193

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 806 Bonaparte
(c) Hospital or institution: (Home) 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3701 Greenmount (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ethel Althea Haynes

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Frank P. Haynes

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) March 25 1868

8. AGE: Years 78 | Months 8 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Massachusetts (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name ? Foss
13. Birthplace Mass.

MOTHER
14. Maiden Name Carolyn Mullikin
15. Birthplace Mass

16 (a) Informant Mrs Jos. H. South (daughter)
(b) Address 3701 Greenmount

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-46 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Sherwood Morris Co.
(b) Address 108 W North Ave.

19 (a) (Date received by registrar) DEC 6 1946 (b) Registrar

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 12/4/46 19__, at ____ M

**21.** I certify that death occurred on the date above stated; that I attended deceased from March 1946 to 4 Dec 1946, and that I last saw h[illegible] alive on 3 Dec 1946.

| | Duration |
|---|---|
| Immediate cause of death: Coronary thrombosis | Few min. |
| Due to: Diabetes Mellitus, Arteriosclerosis | Unknown |
| Due to: Hypertension | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)

Date of operation April 1946.

Major findings of operation: Carcinoma right breast with metastases

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William C. Deaver M. D.
Address 3025 Belair Rd. Date signed 12-4-46

Huntington Williams, M.D.

AC 64083
G46194

BALTIMORE CITY HEALTH DEPARTMENT X G46194

# CERTIFICATE OF DEATH 159

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address DuKalanda Rayner Ave.
(c) Hospital or institution: W. Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 6

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Balto. 14 (If outside city or town limits, write RURAL and give town)
(d) Street No. Ridgely Oak Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Edward Leyhe

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Wh | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/28/46

8. AGE: Years | Months | Days: 6 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Phillip Leyhe
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Genevieve Tollasci
15. Birthplace Balto. Md.

16 (a) Informant Phillip Leyhe
(b) Address Balto 14 Ridgley Oak Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 mo. 6 dys. (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Charles P Towell
(b) Address 24-27 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 1a DEC 6 - 1946 Huntington Hillcrest, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-4 1946 at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-28 1946 to 12-4 1946 and that I last saw him alive on 12-4 1946

Immediate cause of death Aspiration pneumonia — Duration

Due to

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: not obtained

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. J. Trepton M. D.
Address W. Balto Gen Hosp Date signed 12-5-46

X

G46195

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G46195 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 537 N. Eutaw St. 12
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2941 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

**3 (a) FULL NAME** Mr. Charles M. Cohn

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| None | 212-05-6460 |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | White | S. |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-25-73

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 7 | 10 | hr. min. |

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Chairman-Board Directors
11. Industry or business Consolidated Gas & Electric Co.

FATHER
12. Name M. G. Cohn
13. Birthplace Bremen, Germany

MOTHER
14. Maiden Name Emily Stoll
15. Birthplace

16 (a) Informant Mr. Charles B. Crane
(b) Address 19th Floor Lexington Bldg.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) DEC 6 - 1946 (b) Registrar Huntington Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5 1946, at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3 1941 to Dec 5 1946, and that I last saw him alive on Dec 5 1946

| Immediate cause of death | Duration |
|---|---|
| Cardio Vascular Accident | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin O. Henderson M. D.
Address Union Memorial Hosp. Date signed 12-5-46

X

G46196

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 195 C

Registered No. G46196

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2431 Maryland Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 - 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2431 Maryland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARGARET ELIZABETH HARROD

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles W. Harrod
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 10, 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 3 | 25 | hr. min. |

9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: George H. (Harrod) Garratt
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Alice McClure
15. Birthplace: Columbia, Pa.

16 (a) Informant: Mr. Charles W. Harrod
(b) Address: 2431 Maryland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/46 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 5, 1946, at 2.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1946 to Dec 5 1946.
and that I last saw h[illegible] alive on Dec 5 1946

Immediate cause of death: Cardiac [illegible]
Due to:
Due to: Senile degeneration

| Duration |
|---|
| 24 hours |
| several years |

Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roscoe Troop M. D.
Address 2438 Maryland Ave Date signed 12-5-46

Huntington Williams, M.D.

X

G46197

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1248

Registered No. G46197

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3819 Cranston Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3819 Cranston Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Agnes Biedenkapp

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Oscar John Frank Biedenkapp

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1905

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 41 | 8 | 23 | hr. min. |

9. Birthplace Bonness, Scotland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Horne
13. Birthplace Bonness, Scotland

MOTHER
14. Maiden Name Agnes Morris
15. Birthplace Bonness, Scotland

16 (a) Informant Mrs. Oscar J.F. Biedenkapp
(b) Address 3819 Cranston Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/46 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 6

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** December 5 1946 at 6:30 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 1940 to Dec 5 1946. and that I last saw h. alive on Dec 4 1946.

| Immediate cause of death | Duration |
|---|---|
| Cerebral thrombosis | 5 min. |
| Due to circulatory collapse | |
| Due to Cirrhosis of Liver | 2 Months |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Cirrhosis of liver —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23. Signature** Edith Mortimer Jr M. D.
Address 2706 St Paul St Date signed 12/5/46

VS 150

X

G46198 BALTIMORE CITY HEALTH DEPARTMENT X G46198

# CERTIFICATE OF DEATH √ 45a

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Broadway + Fairmont Aves.
(c) Hospital or institution:
Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Worster.
(c) City or town Pocomoke, City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 605 Second
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Robert J. Lambden

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed.

6 (b) Name of husband or wife Ella Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 29. 1862

8. AGE: Years 84 | Months 7 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business —

FATHER
12. Name R. J. Lambden
13. Birthplace Maryland

MOTHER
14. Maiden Name Charlett Ross.
15. Birthplace Maryland.

16 (a) Informant Patient - Deceased
(b) Address

17 (a) Burial (b) Date thereof Dec 8-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Private Cem
Location Pocomoke, Md

18 (a) Funeral director H. Harry Bradshaw
(b) Address Pocomoke, Md

19 (a) ____ (b) ____
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 5 1946, at 8:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-29 1946, to 12-5 1946, and that I last saw him alive on 12-5 1946.

| Immediate cause of death | Duration |
|---|---|
| Cardio-respiratory failure | |
| Due to | |
| Due to | |
| Other Conditions Carcinoma of larynx Sept. | |

(Include pregnancy within 3 months of death)

Date of operation 11-30-46

Major findings of operation: Carcinoma of larynx Epi

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. F. Jordan M. D.

Address Church Home Hosp. Date signed 12-5-46

Huntington Williams, M.D.

X

G46199

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

G46199 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 836 S. Paca St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21-1
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 836 S. Paca St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Elizabeth (Bessie) Pamelia Lahmer

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Theodore P. Lahmer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 28, 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 9 | 7 | hr. min. |

9. Birthplace Schenectady, N. Y. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Joyce
13. Birthplace Pikesville, Md.

MOTHER
14. Maiden Name Sophia ?
15. Birthplace Unknown

16 (a) Informant Mrs. Muriel Santmyer
(b) Address 836 S. Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 7, 1946 (month) (day) (year)
(c) Cemetery or crematory Stone Chapel Cemetery
Location Pikesville, Md.

18 (a) Funeral director Theodore Lahmer
(b) Address 1003 W. Baltimore St.

19 (a) (Date rec'd by Local Registrar) (b) DEC 6 - 1946 Washington Metropolitan

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 5 1946 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-30 1946 to 12-5 1946 and that I last saw her alive on 12-5 1946

| Immediate cause of death | Duration |
|---|---|
| Acute Cardiac Failure | 1 da |
| Due to Cardiovascular Renal Disease | npr |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph G. Laukaitis M. D.
Address 679 Washington Blvd. Date signed 12/5/46

VS 150

X

G46200

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V 131a

Registered No. G46200

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 222 S Fremont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21-
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Basto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 222 S Fremont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** James J. Magee

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 27 1876

8. AGE: Years 69 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace Basto. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Magee
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Keffy
15. Birthplace Basto

16 (a) Informant Gertrude Lyons
(b) Address 222 Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director M. W. E. Lynch's Sons
(b) Address Lombard & Bond Sts.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 6 1946

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4 1946 at 8:45 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/10 1946 to 12-4 1946 and that I last saw h[illegible] alive on 12/4 1946

Immediate cause of death: Acute Cardiac Failure — Duration: 1da

Due to: Cardiac & Colon Renal Disease — Duration: yrs

Due to: — Duration:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph G Lankaitis M. D.
Address 6 W Madison St Date signed 12/4/46

Huntington

X

G46201

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V830

G46201 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 316 N. Poppleton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 316 N. Poppleton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Fooks Folks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John Folks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | | | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Edward Dennis
13. Birthplace Md.

MOTHER 14. Maiden Name Mary ?
15. Birthplace Md.

16 (a) Informant Charles Wells
(b) Address 1618 Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 6, 1946 (month) (day) (year)
(c) Cemetery or crematory Laurel Cem.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 2201 Pennsylvania Ave

19 (a) (Date rec'd by registrar) (b) Registrar

V S 150 DEC 6 - 1946 Washington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2 1946, at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3 1946, to Dec. 2 1946, and that I last saw her alive on Dec 2 1946.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to

Due to Hypertension (Malignant)

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Grant Hinkley

Address 343 Penna. Ave Date signed 12/7/46

G46202
CHK-100642

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1312

G46202
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7m 15d
(e) Length of stay in Baltimore (yrs., mos., or days) 42 Years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (Curtis Bay)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1509 Oakland Street - 26 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Joseph Michael Lacher

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23-1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 11 | 7 | hr. min. |

9. Birthplace New Jersey (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Michael Lacher
13. Birthplace Germany

MOTHER
14. Maiden Name Dorethe ?
15. Birthplace Germany

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-7-1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1476 Light St.

19 (a) (Date rec'd by registrar) (b)

DEC 6 - 1946

Huntington Williams Registrar

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH November 30 1946 at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1946 to Nov. 30 1946 and that I last saw him alive on Nov. 30 1946.

Immediate cause of death
Respiratory failure
Due to Miliary Tuberculosis
Due to
Other Conditions Jaundice, Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy Miliary Tuberculosis

Duration

over

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Doyle Waldron M. D.
Address B.C.H. Date signed 12/5/46

G46203

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 194a

G46203 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-19
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** ANNA ROSENKOVITZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1858

8. AGE: Years 88 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name unknown

13. Birthplace Russia

MOTHER 14. Maiden Name unknown

15. Birthplace Russia

16 (a) Informant Sam Rosen

(b) Address 803 Augusta St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-46 (month) (day) (year)

(c) Cemetery or crematory Friendship Cem

Location Hebrew

18 (a) Funeral director Jack Lewis Inc

(b) Address 1479 E Balto St

19 (a) DEC 6 - 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-5 1946 at 3 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 1941 to 12-5 1946 and that I last saw h[illegible] alive on 12-5 1946

Immediate cause of death Coronary thrombosis — Duration

Due to

Due to

Other Conditions Cerebral arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Nagel M. D.

Address Levindale Home Date signed 12-5-46

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

G46204

Registered No. G46204

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 209 S. Eaton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] HIMMELSERB

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Fred Himmelsberb

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Oct 24 1882

8. AGE: Years 64 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace Rotterdam, Holland (Town, county, and state)

10. Usual Occupation House-Wife

11. Industry or business At home.

FATHER
12. Name Wilhelm Boeren
13. Birthplace Holland

MOTHER
14. Maiden Name Helena Mosman
15. Birthplace Holland

16 (a) Informant Fred Himmelsberb
(b) Address 209 S Eaton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-9-46. (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave.

18 (a) Funeral director Charles S. Zeiler
(b) Address 3605 Gait Ave.

19 (a) [illegible] (Date rec'd by registrar) (b) [illegible]

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/5/46 19.., at 7.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/20 1946 to 12/5 1946 and that I last saw H.E.R. alive on 12/4 1946.

Immediate cause of death CONGESTIVE HEART FAILURE — Duration 5 DAYS

Due to HYPERTENSIVE CARDIO-VASCULAR RENAL DISEASE

Due to

Other Conditions AURICULAR FIBRILLATION
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles W. Stewart, Jr. M. D.
Address MD. GENERAL HOSP. Date signed 12/5/46

VS 150

G46205

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G46205 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 133 N. Linwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 133 N. Linwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Wirth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Jno. Wirth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1867

8. AGE: Years 79 | Months 6 | Days 6 | If less than one day ..... hr. ..... min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business House - Work

FATHER
12. Name ? Helgert
13. Birthplace Germany.

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany.

16 (a) Informant Anthony Hautmer
(b) Address 133 N. Linwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-7-46. (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd.

18 (a) Funeral director Charles S. Zeiler
(b) Address 3605 Fait Ave.

19 Date received by local registrar DEC 6 1946 (b) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 4 1946 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1946 to Dec 4 1946 and that I last saw h[illegible] alive on Dec 3 1946

Immediate cause of death Coronary Occlusion — Duration 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fred Rupprecht M. D.
Address 600 N Fulton Ave Date signed 12-7-46

Huntington Williams, M.D.

G46206

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 56E

Registered No. G46206

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1213 Hanover St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 Hanover St., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary E. Smith

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or ~~wife~~ Edward Smith
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 27, 1869
8. AGE: Years 77 | Months 6 | Days 7 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name James Horan
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Sparklin
15. Birthplace Md.

16 (a) Informant Mrs. William Heiger
(b) Address 1213 Hanover St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-7-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director L. Howard Strong
(b) Address 3207 W. North Ave. Baltimore Md.

19 (a) (Date received by registrar) (b) Registrar

DEC 6 - 1946

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 4, 1946 at 2.25 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to Dec 4 1946, and that I last saw her alive on Dec 4 1946

Immediate cause of death: an enlargement like Hematoma in gastric region

Due to:

Due to:

Other Conditions: General debility

(Include pregnancy within 3 months of death)

Date of operation: no operation

Major findings of operation:

of autopsy:

Operation: upper

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 1213 Hanover St. Date signed Dec 5 1946 M. D.

X

G46207

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G46207

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3820 Bonner Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-9
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto-
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3820 Bonner Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George William Myers

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30 1877

8. AGE: Years 74 | Months 7 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired Draftsman

11. Industry or business Balto City

FATHER
12. Name John J. Myers
13. Birthplace Germany

MOTHER
14. Maiden Name Mary E. Dunn
15. Birthplace Balto. Md

16 (a) Informant Mrs Rose E. Myers
(b) Address 3820 Bonner Road

17 (a) Burial (b) Date thereof 12-6-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director G Howard Strong
(b) Address 3207 W North Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

DEC 6 1946

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 4 1946, at 2 10 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Neilson M.D.
Medical Examiner.
Date signed Dec 5-1946

VS 151

6208

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 47a

Registered No. G46208

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution:
Univ Hosp 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 45 y

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3241 Chestnut Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Edward Cumor

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213 26 7010

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife Hattie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | | | hr. min. |

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Produce Business

11. Industry or business

FATHER
12. Name William Cumor
13. Birthplace Md.

MOTHER
14. Maiden Name — W Leeler
15. Birthplace Pennsylvania —

16 (a) Informant Hattie Cumor
(b) Address same —

17 (a) Burial (b) Date thereof 12-9-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Mem Park
Location Baltimore Md

18 (a) Funeral director Frank H Leahy
(b) Address 814 N 36 St

19 (a) Date rec'd by registrar (b) Huntington Williamsburg

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 12-5 1946 at 2:50 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 12-4 1946 to 12-5 1946 and that I last saw h alive on 12-5 1946.

| Immediate cause of death | Duration |
|---|---|
| Metastatic Carcinoma from Laryngeal generalized | |
| Due to | |
| Due to | |
| Other Conditions Abd distention ascites melena & nasal bleeding (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature G. K Driggs MD M. D.
Address Univ Hosp Date signed 12-5-46

VS 150

G46209

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G46209

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 minutes
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1324 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John B Mayer

(b) If veteran, name war

3 (c) Social Security Account No. 177-14-3453

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

(b) Name of husband or wife Helen M. Clark

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) June 14 1883

| AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 5 | 21 | hr. min. |

8. Birthplace Philadelphia Pa.
(Town, county, and state)

10. Usual Occupation medical physician
11. Industry or business B & O R.R.

12. Name John B. Mayer
13. Birthplace Germany
14. Maiden Name Katharina Trautz
15. Birthplace Philadelphia, Pa

16 (a) Informant Helen M. Mayer
(b) Address 1324 Eutaw Place

17 (a) removal (b) Date thereof 12/6/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hillside
Location Phila. Pa.

18 (a) Funeral director H. W. E. Dippel's Sons
(b) Address Lombard & Ann Sts.

DEC 6 1946 (c) Huntington Williams M.D.
Date rec'd by registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/5 1946, at 8:20 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive C.V. Disease
a. Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Lubinski M.D.
Medical Examiner.
Date signed 12/6/46

X

6210

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13B

Registered No. G46210

**PLACE OF DEATH:**
1) Baltimore City, Maryland
2) Street address.....
3) Hospital or institution: Johns Hopkins Hosp. 8-7
4) Length of stay in hospital or inst. (yrs., mos., or days) 1'
5) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 N. Dallas St. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

(a) FULL NAME Katherine Townes

(b) If veteran, name war

3 (c) Social Security Account No.

Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

(b) Name of husband or wife.....

6 (c) If alive, give age—— years

Birth date of deceased (mo., day, yr.) April 10, 1928

| AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 18 | 7 | 26 | ....hr. ....min. |

Birthplace Nottaway Va. (Town, county and state)

Usual Occupation.....

Industry or business

12. Name Charles Townes

13. Birthplace Virginia

14. Maiden Name Lacie Johnson

15. Birthplace Virginia

(a) Informant Lucy Townes

(b) Address 1310 Dallas St.

(a) Burial (Burial, cremation, or removal) (b) Date thereof 12-8-46 (month) (day) (year)

(c) Cemetery or crematory Crew Za.

Location.....

(a) Funeral director George G. Nelson

(b) Address 1303 Pennsylvania Ave

DEC 6 - 1946 (Date rec'd by Registrar) (b) Howard Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 6, 1946 at 1:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Enquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary tuberculosis

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury..... at..... M.

(b) Where did injury occur?.....

(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....

(d) Means of injury.....

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 12-6-46

VS 151

G16211

BALTIMORE CITY HEALTH DEPARTMENT X

# CERTIFICATE OF DEATH ✓ 49a

G16211 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution:
Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State ~~Md.~~ D.C. (b) County Balto.
(c) City or town Rural Raspeburg
(If outside city or town limits, write RURAL and give town)
1006 NEBSTER, STREET, N.W.
(d) Street No. Brooks Sanatorium Rd
WASH. D.C. - (If rural give location)
(e) Citizen of foreign country? ~~Md~~ (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs M. Cecelia Courtenay (COURTNAY).

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife Edw. H. Courtenay
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1901

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 45 | 03 | 15 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Nurse.
11. Industry or business None

FATHER
12. Name George Barnes
13. Birthplace Wash. D.C.

MOTHER
14. Maiden Name Mary Vance
15. Birthplace Balto. Co. Md.

16 (a) Informant Mrs. Cecelia Courtenay
(b) Address (Same as above)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-9-46 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location Balto.

18 (a) Funeral director J. Liston Wiedefeld.
(b) Address Greenmount Ave & 22nd St.

19 (a) (Date rec'd by registrar) (b) Registrar
Huntington Williams, M.D.

VR 150
DEC 6 - 1946

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Dec. 4 1946, at 5-33 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 19 46 to Dec. 4 1946, and that I last saw her alive on Dec. 4 19 46.

Immediate cause of death Generalized Carcinomatosis - Ovarian origin — Duration: 1 yr +

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation July 22, 1946

Major findings of operation: Gen. Canc.

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William D. Stanley Jr. M.D.
Address Mercy Hosp. Date signed 12-4-46

A 51617 G46212 BC# G59941

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1190

Registered No. G46212

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 149 Exeter St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Irakin Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/21/46

8. AGE: Years | Months 1 | Days 8 | If less than one day hr. min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Andrew Thomas
13. Birthplace D. C.

MOTHER
14. Maiden Name Benitta Merritt
15. Birthplace md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School DEC 6 1946 Location

18 (a) Funeral director Commissioner of Health
(b) Address
DEC 6 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1946 at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 25 1946 to Nov. 29 1946, and that I last saw him alive on Nov. 29 1946

Immediate cause of death: SEVERE MALNUTRITION — Duration: LIFE

Due to

Due to

Other Conditions: ACUTE NUTRITIONAL DISTURBANCE — 5 days
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul H. Maclay M. D.
Address Johns Hopkins Hosp. Date signed 11/29/46

VS 150

G46213

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 181

G46213

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address none
(c) Hospital or institution:
U.M.H 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:** none given
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2422 N. Gilmor St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Elmer Sherry

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| W | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | S |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 11 1902

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 44 45 | 10 | 24 | hr. min. |

9. Birthplace Baltimore Maryland.
(Town, county, and state)
10. Usual Occupation none.
11. Industry or business none.

FATHER
12. Name W. B. Sherry
13. Birthplace Maryland.

MOTHER
14. Maiden Name Matilda E. Wendel
15. Birthplace Maryland.

16 (a) Informant Brother
(b) Address Maryland.

17 (a) Burial (b) Date thereof 12/6/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Wilson & Son
(b) Address 1217 W. Pratt St.

19 (a) (b)
(Date rec'd by Registrar)

DEC 6 - 1946

VS T50

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Dec 5th 1946; at 6.45 AM

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec 3 1946, to Dec 5 1946, and that I last saw him alive on Dec 5 1946.

Immediate cause of death Heart failure

| Duration |
|---|
| |
| |
| |
| |

Due to Acidosis + Shock

Due to Burns + methylalcohol

Other Conditions Bronchitis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 13/1
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Dec 3 at 10 A.M.
(c) Where did injury occur? Baltimore Baltimore Maryland
(City or town) (County)
(d) Did injury occur about home, on farm, industrial place, in public place? public While at work? no
(Specify type of place)
(e) Means of injury Burned in bon fire

23. Signature G. H. Klumpar Jr.
Address Union Memorial Hospital Date signed 12/6/46
M. D.

Huntington Williams, M.D.
George H. Merrill

11 G46214

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 178a

G46214 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 922 Hollins St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Alex Dominik - Alexander Dominikaitis

(b) If veteran, name war ✓

3 (c) Social Security Account No. 215-01-5973

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

(b) Name of husband or wife Kazimiera Dominikaitė

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Dec 11 1881

8. AGE: Years 65 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace Lithuania
(Town, county, and state)

10. Usual Occupation TAILOR

11. Industry or business

12. Name Kazis Dominikaitis

13. Birthplace Lithuania

14. Maiden Name Ursula Shalashaviciute

15. Birthplace Lithuania

16. (a) Informant Kazimiera Dominikaitė

(b) Address 164 Sargeant St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-7-46 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Belair Rd.

18. (a) Funeral director Charles W. Kaelin

(b) Address 637 Washington Blvd

19. (a) (b) Registrar
(Date received by registrar)

DEC 6 - 1946 Washington Village, Md

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/4 1946, at 8:20 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐ Probable suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxia due to illuminating gas -
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/4/46 at about 5:00 P M.
(b) Where did injury occur? 922 Hollins St
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Gas inhalation from fire and its burners

23. Signature C. J. Jakimski M.D.
Medical Examiner.
Date signed 12/4/46

X

G46215

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G46215

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hosp. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3223 Montebello Terrace
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Frederick Melvin Reapsomer (FREDERICK MELVIN REAPSOMER)

3 (b) If veteran, name war: WORLD WAR # 1

3 (c) Social Security Account No. 216-09-3895

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs. F.M. Reapsomer

6 (c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): May 10 1894

8. AGE: Years: 52 | Months: 6 | Days: 24 | If less than one day: — hr. ... min.

9. Birthplace: Md
(Town, county, and state)

10. Usual Occupation: Accountant

11. Industry or business: —

FATHER
12. Name: Mr John M. Reapsomer
13. Birthplace: Md.

MOTHER
14. Maiden Name: Laura Haupt
15. Birthplace: Md.

16 (a) Informant: Mrs F.M. Reapsomer
(b) Address: 3223 Montebello Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/46 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) ... (b) Huntington Woods (Date rec'd by registrar)

DEC 6 - 1946

VS-150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-4 1946, at 3:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-2 1946 to 12-4 1946, and that I last saw h[illegible] alive on 12-3 1946.

Immediate cause of death: Pulmonary edema

Due to: Hypertensive cardiovascular disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: H. Lapham Sprawl M. D.

Address: Union Mem. Hosp. Date signed: 12-4-46

G46216

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1/31a

G46216 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2901 Dillon Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2901 Dillon Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARY FRANCIS BALLANCE

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widow |

6 (b) Name of husband or wife Levi Ballance
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1857

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 89 | 4 | 29 25 | hr. min. |

9. Birthplace North Carolina
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Payner
13. Birthplace North Carolina

MOTHER
14. Maiden Name Nancy Brown
15. Birthplace North Carolina

16 (a) Informant Cap't John M. Kendley
(b) Address 2901 Dillon Street

17 (a) Burial (b) Date thereof 12/7/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (b)
(Date rec'd by registrar) Registrar

DEC 6 1946

VS 150

**MEDICAL CERTIFICATION** PM

20. DATE OF DEATH Dec. 4 1946, at 8.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 2 1946 to Dec. 4 1946 and that I last saw h[illegible] alive on Dec. 4 1946.

| Immediate cause of death | Duration |
|---|---|
| Cardiac Failure | |
| Due to Arteriosclerotic Cardio-Vascular Renal disease | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L B Stevens M. D.
Address 3402 Eutaw ave Date signed 12/5/46

Huntington, West Virginia

X

G46217

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G46217

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give county)
(d) Street No. 638 N Fremont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME Howard Taylor

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: Single

(b) Name of husband or wife:

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1881

| AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 9 | 28 | hr. min. |

8. Birthplace Baltimore, md. (Town, county and state)

10. Usual Occupation Unemployed
11. Industry or business

12. Name Unknown
13. Birthplace Unknown
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Lillian Baker
(b) Address 908 Little Pine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 10, 1946 (month) (day) (year)
(c) Cemetery [redacted] Mt. Calvary
Location Cedar Hill md.

18 (a) Funeral director Jos. Halstead
(b) Address 1718 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4 1946, at 11:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William S Kelsick M.D. Medical Examiner
Date signed DEC 5-1946

VS 151

G46218 G46218

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1310

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Gran Sts
(c) Hospital or institution:
University Hosp 16-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 Raynor Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sheldon Elby Bowman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Winifred Long 42
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1903

8. AGE: Years 46 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Calvin Huntingdon Co. Pa
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Public Works

FATHER
12. Name Simpson Bowman
13. Birthplace Cass Twp Hunt Co. Pa

MOTHER
14. Maiden Name Julia Hazzard
15. Birthplace Calvin Pa.

16 (a) Informant Wmfred Bowman
(b) Address 2109 Raynor ave Baltimore

17 (a) Burial (b) Date thereof Dec 9 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baptize
Location Calvary Pa

18 (a) Funeral director F. A. Whitehurst Son
(b) Address 1330 Eutaw Pl

19 (a) (Date received by registrar) Clayton Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6, 1946; at 3:1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw him alive on Dec 6 1946.

Immediate cause of death Pulmonary edema — Duration

Due to Hypertensive Cardiovascular

Due to Chr Glom Nephritis

Other Conditions Brain lesion probably as sequel of embolism
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. L. Briggs M. D.
Address Univ Hosp Date signed 12-6-46

VS 150

G46219

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 837

G46219
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4607 Kilmslow Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-
(e) Length of stay in Baltimore (yrs., mos. or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4607 Kilmslow Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs. Florence Lillian Johnson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lee Burns Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5-1892

8. AGE: Years 54 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Milton Ruby
13. Birthplace Maryland

MOTHER 14. Maiden Name Rosa Griffith
15. Birthplace Maryland

16 (a) Informant Lee B. Johnson
(b) Address 4607 Kilmslow Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 7-1946 (mo.), (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Fpls Road

19 (a) (Date filed by registrar) (b) Registrar

1946 Huntington Hillcrest

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4- 1946, at 10 58 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1945 to Dec 4 1946 and that I last saw h alive on Dec 4 1946

Immediate cause of death Hemiplegia. left side — Duration 10 days
Due to Arteriosclerosis & hypertension — Indefinite
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathaniel M Beck
Address 100 E. 23rd St Date signed (M. D.) Dec 5-46

VS 150

X

16220

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G16220

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2711 Northern Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2711 Northern Parkway (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Sanda

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John Sanda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1858

8. AGE: Years 88 | Months 6 | Days 17 | If less than one day: hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER — 12. Name Joseph Hovin
13. Birthplace Austria

MOTHER — 14. Maiden Name Mary Hemphal
15. Birthplace Austria

16 (a) Informant Antonia Sanda
(b) Address 2711 Northern Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 7/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Heath Bradley
(b) Address 900 N. Chester St

19 (a) Dec 6 1946 (Date rec'd by registrar) Huntington Willis (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4 1946, at 1030 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 1946 to 12/7 1946, and that I last saw h[illegible] alive on 12/4 1946

| Immediate cause of death | Duration |
|---|---|
| Arteriosclerotic cardio-vascular disease | 2 yrs |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold A. Pratt M. D.
Address 8100 Harford Rd Date signed 12/11/46

VS 150

G46221

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 B

Registered No. G46221

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Lafayette & John Sts.
(c) Hospital or institution: Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 24
(e) Length of stay in Baltimore (yrs., mos., or days) —

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimare
(c) City or town Baltimare (If outside city or town limits, write RURAL and give town)
(d) Street No. 211 E. Fort Ave (If rural give location)
Citizen of foreign country? NA (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Talbott

3 (b) If veteran, name war NO
3 (c) Social Security Account No. none

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mr. Joshua Talbott
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Jan 25, 1900

8. AGE: Years 46 | Months 11 10 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace Irlch, Germany (Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business None

FATHER
12. Name John Dames
13. Birthplace Irlch, Germany

MOTHER
14. Maiden Name Agnes Antwieler
15. Birthplace Irlch, Germany

16 (a) Informant Deceased
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/46 (months) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Mullen & Son Inc
(b) Address 1219 E Fort Ave

19 (a) ____ (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

DEC 9 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 1946, at 2 42 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 18 1946, to Dec 6 1946, and that I last saw her alive on Dec 6 1946.

Immediate cause of death: Carcinoma of Stomach — Duration: ____

Due to: ____ — Duration: ____

Due to: ____ — Duration: ____

Other Conditions: ____ — Duration: ____

(Include pregnancy within 3 months of death)

Date of operation: ____

Major findings of operation: ____

of autopsy: ____

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: ____
(b) Date of occurrence: ____ at ____ M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ (Specify type of place) While at work? ____
(e) Means of injury: ____

23. Signature Frank H. Logan M. D.
Address Hosp for Women of Md Date signed Dec 46

G16222

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G16222

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 837 N Chapel St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town insert RURAL and give town)
(d) Street No. 837 N Chapel St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME Anna Knickton

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Mard

(b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 27 1860

8. AGE: Years 86 | Months 11 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant Hazel Flood

(b) Address 3126 Elrath St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/46 (month) (day) (year)

(c) Cemetery or crematory Johnnies

Location Forest Park

18 (a) Funeral director William Cook Sons

(b) Address 1219 N Fulton Ave Baltimore, Md

DEC 6 1946 (b) Registrar

Date rec'd by registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4 1946, at 8:15 P M

21. I certify that I took charge of the remains described above, held an Autopsy Ed Chig thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William S Helfrich M.D. Medical Examiner

Date signed Dec 5 1946

X

G46223

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G46223

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 515 E 27th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 E 27th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Grace Radley

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| — | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Joseph D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 11 1869

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 9 | 24 | hr. min. |

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Gordon Kendrick
13. Birthplace Va

MOTHER
14. Maiden Name Gertrude Harrenhorst
15. Birthplace

16 (a) Informant Joseph Radley
(b) Address 515 E 27th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/46 (month) (day) (year)
(c) Cemetery or cremator Mt Olivet
Location Baltimore Md

18 (a) Funeral director Wm Cox Sons
(b) Address 1217 E Fort Ave

19 DEC 6 1946 (b) Huntington for Nathaniel Mrs
(Date rec'd by Registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3 1946 to Dec 5 1946 and that I last saw h&r alive on Dec 5 1946.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 6 |
| Due to Rupture Cerebral Vessel | 6 |
| Due to Arteriosclerosis | ? |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature K. Brulenty M. D.
Address 2116 W. Pratt St Date signed 12/10/46

VS 150

G46224

J- 94429

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

G46224 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
-1 - 5 -6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 4
(d) Street No. 1809 Covington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Daniel Stubbins

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Gloria
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 4 | 13 | hr. min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Bricklayer
11. Industry or business

FATHER
12. Name Joseph Stubbins
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Baitzell
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/46 (month) (day) (year)
(c) Cemetery or crematory London Pk.
Location Baltimore City

18 (a) Funeral director William Cook Inc
(b) Address 1212 St Paul St

19 DEC 6 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4 1946, at 7.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 1945 to Dec. 4 1946, and that I last saw him alive on Dec. 4 1946

| Immediate cause of death | Duration |
|---|---|
| Subarachnoid Hemorrhage | 12 hrs. |
| Due to Hypertensive Heart Disease | 10 yrs. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.
Address Balto City Hosp. Date signed 12/5/46

VS 150

G46225

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 163 X

G46225 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 4307 Greenmount Ave 27

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4307 Greenmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME GRACE WELLS

(b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

(b) Name of husband or wife: John H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28 1886

8. AGE: Years 60 | Months 9 | Days 27 | If less than one day hr. min.

9. Birthplace New York City
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Mathew Fitzgerald

13. Birthplace Ireland

14. Maiden Name Dena Wallace

15. Birthplace Ky

16 (a) Informant John H. Wells

(b) Address 4307 Greenmount Ave

17 (a) Cremated (b) Date thereof 12/6/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Kensico Cem

Location New York City

18 (a) Funeral director Wilson & Son Inc

(b) Address 1217 E. Fayette St

19 (a) DEC 6 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 5 1946, at 6 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chloroform Poisoning.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/5/46 at 5 P.M.
(b) Where did injury occur? 4307 Greenmount ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Chloroform Fumes. Overcome by

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 12/6/46

VS 151

G46226 — 505158

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 157E

Registered No. G46226

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Ohio (b) County.....
(c) City or town Cleveland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1735 Parkemount Ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

**3 (a) FULL NAME** James P Longer

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 3-6-44.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 2 | 9 | 29 | ..... hr. ..... min. |

9. Birthplace Ohio
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business

**FATHER**
12. Name William S Longer
13. Birthplace N.Y.

**MOTHER**
14. Maiden Name Juanita L.
15. Birthplace Ohio

16 (a) Informant Rec. Dept. JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 6/46 (month) (day) (year)
(c) Cemetery or crematory.....
Location Cleveland Ohio

18 (a) Funeral director Philip Henrich Sons
(b) Address 2024 Eutaw St

19 (a)..... (b)..... (Date rec'd by registrar)

DEC 6 - 1946

VS 150

Huntington Mill Registrar MD

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec. 5 1946 at 1:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 23 1946, to Dec. 5 1946, and that I last saw him alive on Dec. 5 1946.

Immediate cause of death Congenital
Heart Block
Due to Pathology of Fallot

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

Date of operation 12/3/46 Palliative
Major findings of operation: Pulmonary stenosis
of autopsy Same

Duration
Hrs.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Henry S. Baker M.D.
Address Johns Hopkins Hosp Date signed 12/6/46

X

16227

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

19 ✓

Registered No. G16227

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 23
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 112 Hammerbacker Court.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME JOSEPH E. JONES

(b) If veteran, name war World War #2

3 (c) Social Security Account No. 275-14-9561

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Single

(b) Name of husband or wife

6 (c) If alive, give age years

Birth date of deceased (mo., day, yr.) July 12, 1905

AGE: Years 40 | Months 4 | Days 21 | If less than one day hr. min.

Birthplace Bluefield, W. Va.
(Town, county, and state)

10. Usual Occupation Car washer

11. Industry or business "Drive Yourself Co

12. Name ?

13. Birthplace ?

14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Willie Hill

(b) Address 112 Hammerbacker Ct.

17 (a) (Burial, cremation, or removal) (b) Date thereof 12 6 46
(month) (day) (year)

(c) Cemetery or crematory Balto. National Cemty

Location Baltimore, Md.

18 (a) Funeral director Walter D. Boyce

(b) Address 139 W. Fayette St.

19 (a) Date rec'd by registrar Huntington Williams

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 3, 1946, at 8.45 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Tuberculosis of cervical lymph-nodes.

Due to

Other Conditions Atrophy of brain

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12/4/46

X

G46228

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

Registered No. G46228

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3444 2nd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3444 2nd St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Eugenia Viola Tubbs

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 9 | 16 | hr. min. |

9. Birthplace Anne Arundel Co. Md. (Town, county, and state)
10. Usual Occupation Restaurant Owner
11. Industry or business

FATHER
12. Name John Tubbs
13. Birthplace Concord, Del

MOTHER
14. Maiden Name Olive Ann Stewart
15. Birthplace Anne Arundel Co. Md.

16 (a) Informant Mrs. J.L. Wesley
(b) Address 422 W. Forest View Rd. Linthicum

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/8/46 (month) (day) (year)
(c) Cemetery or crematory Friendship Cem.
Location A. A. Co. Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pa. Aves

19 DEC 6 1946 (Date received by) (b) Registrar

V S 150

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH Dec. 5 1946, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1942, to Dec. 5 1946 and that I last saw her alive on Dec. 5 1946.

| Immediate cause of death | Duration |
|---|---|
| Cerebral hemorrhage | 24 hrs. |
| Due to Arsenal Hy Parkerson + | |
| Due to Sclerosis | 3 yrs. |
| Other Conditions Chronic Nephritis | 4 yrs. |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P. J. Donnelan M. D.
Address 4609 Gst. Ritchie Hwy signed Dec. 6, 1946

Recorded 1946 Huntington Williams, M.D.

G46229

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G46229

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home Hospital 6 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2122 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME M. Horace Freely BREELEY

(b) If veteran, name war: World War 1

3 (c) Social Security Account No.

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: S

(b) Name of husband or wife

6 (c) If alive, give age 897 years

7. Birth date of deceased (mo., day, yr.) Nov. 19 (1895)

AGE: Years 49 | Months 0 | Days 16 15 | If less than one day ____hr. ____min.

8. Birthplace Baltimor
(Town, county, and state)

9. Usual Occupation none

10. Industry or business

11. Name of father Joseph

12. Birthplace of father Baltimor

13. Maiden Name of mother Mary M'Sherry

14. Birthplace of mother Baltimor

15. (a) Informant Mrs Newman

(b) Address 1531 n Bond St

16. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/46 (month) (day) (year)

(c) Cemetery or crematory Balto Nat

Location Frederick Rd

17. (a) Funeral director Blaume & Hoffman

(b) Address 1639 Broadway

(a) (Date received by registrar) (b) Huntington Williams Registrar

VS 1 DEC 6 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-4-1946, at 3 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary — Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12/5/1946

X

G46230

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1312

G46230 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1807 Dallas St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-5
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 Dallas St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Robert I. Baker

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | W |

6 (b) Name of husband or wife Helen E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1870.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 0 | 8 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

MOTHER / FATHER
12. Name John
13. Birthplace Carroll Co. Md.
14. Maiden Name Mary McCreagan
15. Birthplace Baltimore

16 (a) Informant Son
(b) Address 1807 Dallas St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 9 1946

VS 186

Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5, 1946, at 4 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10, 1945, to Dec. 5, 1946, and that I last saw h[illegible] alive on Dec. 5, 1946.

| Immediate cause of death | Duration |
|---|---|
| Uremia | 2 days, |
| Due to Chronic Nephritis | 3 yrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ernest Lewy, M.D.
Address 164 N. Broadway Date signed 12/6/46

X

Birth Certificate
46231 #-6431/3

BALTIMORE CITY HEALTH DEPARTMENT X V
# CERTIFICATE OF DEATH 159

Registered No. C46231

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County B. C.
(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. Morris Hill Court Oak St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Cooper

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Black | Single |

6 (b) Name of husband or wife: None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 0 | 0 | 2 | 2 hr. 15 min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Ernest Charles Cooper
13. Birthplace Eastern Shore, Maryland

MOTHER
14. Maiden Name Hilaria Fried
15. Birthplace Baltimore, Maryland

16 (a) Informant Hilaria Cooper
(b) Address Morris Hill Court Oak St. Box 83A

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 6 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 6 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4 1946, at 10:35 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 2 1946, to Dec. 4 1946, and that I last saw him alive on Dec. 4, 1946

| Immediate cause of death | Duration |
|---|---|
| Anoxia | |
| Due to Atelectasis | |
| Due to | |
| Other Conditions Prematurity | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B Fox M. D.
Address Univ. Hospital Date signed 12-4-46

VS 150

Birth Registered
162326-64297

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 161c

Registered No. G46232

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1213 Lytle Street
(c) Hospital or institution: South Baltimore Gen'l Hosp 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 4 hrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore 26
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4214 Curtis Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Johnson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | — |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 Dec. 46.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | 4 hr. 30 min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Chester Percey
13. Birthplace New York City NY.

MOTHER
14. Maiden Name Beatrice Kathleen Johnson
15. Birthplace Baltimore, Md

16 (a) Informant mother
(b) Address same as above

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 6 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) 12-6-1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1946, at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Dec 1946 to 3 Dec 1946, and that I last saw her alive on 2 Dec 1946.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Hemorrhage into brain | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy: Hemorrhage into brain

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Cohen M. D.
Address South Balto Gen'l Hosp Date signed 12/4/46

VS 150

G46233

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13B

Registered No. G46233

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Det.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 W Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME Bessie Coates

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (d) Single, married, widowed, or divorced. ?

(b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1922

| AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 24 | | | hr. min. |

8. Birthplace ?
(Town, county, and state)

9. Usual Occupation ?
10. Industry or business

12. Name Unknown
13. Birthplace
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory University Medical School DEC 6 1946
Location

18 (a) Funeral director Commissioner of Health
(b) Address

DEC 6 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11/16 1946, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to hir death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pulmonary TBc

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature G. H. Lubinsky M.D.
Medical Examiner.
Date signed 11/16/46

VS 191

G46234

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93

Registered No. G16234

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Waldorf Court Apts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME IDA M. YANCEY

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Single

(b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 50 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace ?
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

12. Name ?

13. Birthplace ?

14. Maiden Name ?

15. Birthplace

16. (a) Informant ?

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

(a) Funeral director

(b) Address

(c) DEC 6 - 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

University Medical School DEC 6 1946 Commissioner of Health

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28, 1946 at 4 a M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration
Due to
(a)

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. F. Lubinski M.D.
Medical Examiner.
Date signed 11-28-46

VS 181

X

46235

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 161a

Registered No. G46235

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 932 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Baby Pierce
(b) If veteran, name war
(c) Social Security Account No.

4. Sex M. | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. Single
(b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 29 1946

8. AGE: Years | Months | Days | If less than one day 15 hr. 30 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business None

12. Name ? ?
13. Birthplace
14. Maiden Name ?
15. Birthplace

16 (a) Informant ?
(b) Address -

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 6 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 6 - 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 181

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1946, at 12 15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Atelectasis neonatorum
Prematurity
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 12/2/46

G46236

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

166

G46236 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital. 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1419- Ashland Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME CHARLES REEVES

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

(b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/10/1905

8. AGE: Years 40 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

12. Name Johnson Reeves

13. Birthplace N. C.

14. Maiden Name Annie Belcher

15. Birthplace N. C.

16 (a) Informant Elizabeth Hembey

(b) Address 1334 Prospect Ave. N.Y.

17 (a) Burial (b) Date thereof Dec. 8 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lawnmont

Location Lafayette Ave. M. C.

18 (a) Funeral director Elroy E. Wilson

(b) Address 1000 Brantley Ave

19 (a) (Date received by registrar) (b) Registrar

DEC 6 - 1946

VS 191

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3, 1946, at 6.05 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wounds of lung

Due to

Other Conditions Intra thoracic hemorrhage

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-3-46 at 6 p. M.
(b) Where did injury occur? Outside Ashland & Caroline St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms automatic

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 12-4-46

G46237

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. G46237

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address CALVERT AND SARATOGA
(c) Hospital or institution:
MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 550 EDMONDSON AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** J. MEREDITH WILLIAR

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | S |

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) JULY 18, 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 4 | 18 | hr. min. |

9. Birthplace BALT. MD.
(Town, county, and state)
10. Usual Occupation RETIRED.
11. Industry or business

FATHER
12. Name HARRY D. WILLIAR
13. Birthplace BALT., MD.

MOTHER
14. Maiden Name CARIE HERRING
15. Birthplace BALT., MD.

16 (a) Informant Harry D. Williar Jr.
(b) Address 310 Elgerale Rd.

17 (a) Burial (b) Date thereof 12/9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) 12-7-46 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 6 1946, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 25 1946 to Dec. 6 1946 and that I last saw him alive on Dec. 6 1946

Immediate cause of death CARDIO-RENAL FAILURE — Duration

Due to CARDIO-RENAL DISEASE-UREMIA

Due to —

Other Conditions ARTERIOSCLEROSIS

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations —

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James A. Roberts M. D.
Address Mercy Hospital Date signed 12-6-46

VS 180

X

6238

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46F

Registered No. G16238

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4019 Roland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4019 Roland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Clara F Mitchell

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| W | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Joseph F
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 2, 1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 0 | 3 | hr. min. |

9. Birthplace Monmouth NJ
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles P Thayer
13. Birthplace NJ

MOTHER
14. Maiden Name Phebe Lafetra
15. Birthplace NJ

16 (a) Informant Oscar A Martenet
(b) Address 7 Mitchell Place Pg

17 (a) Burial (b) Date thereof 12/9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Friends Burial Ground
Location Baltimore Md

18 (a) Funeral director Wilhoyte & Son Inc
(b) Address 1219 E Lord Ft

19 (a) DEC 7 - 1946 (b) Signature Wilhoyte & Williams M.D.
(Date rec'd by registrar) (Signature)

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Dec 5 1946, at 5 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 12-1 1946 to 12-5 1946 and that I last saw h W alive on 12-5-1946

Immediate cause of death Coronary Occlusion Arteriosclerosis

| Duration |
|---|
| |

Due to

Due to

Other Conditions Hemiplegia Malignant Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature Samuel D Hankin M. D.
Address 7351 E Lord Ft Date signed 12-6-46

VS 150

6239

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G46239
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3103 Chelsea Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3103 Chelsea Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Austin F Schmidt

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| W | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Helen C
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 18 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 3 | 18 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Frederick Schmidt
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Julia Mary
15. Birthplace Baltimore Md

16 (a) Informant Helen Schmidt
(b) Address 3103 Chelsea Terrace

17 (a) Burial (b) Date thereof 12/9/46
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 E. Paul St.

19 (a) DEC 7 - 1946 (b) Huntington Williams M
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 6 1946, at 3:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1946, to Dec. 6 1946, and that I last saw him alive on Nov. 15 1946.

| | Duration |
|---|---|
| Immediate cause of death: Coronary occlusion (thrombosis) | 4 mo |
| Due to arteriosclerotic heart disease | 4 mo. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Percy H. Sutley M.D.
Address 3417 Gunyons Falls Pk. Balt. Date signed Dec 6, 46

VS 150

X

6240½ W Fayette St. DOOMS

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13 B

Registered No. G46250

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3636 Hennick Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3636 Hennick Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** William A. Dooms.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Fannie F. Dooms
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Oct 15 (1879) 1879

8. AGE: Years (6)67 | Months 1 | Days 20 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Cement Finisher
11. Industry or business Retired

FATHER
12. Name Jacob Dooms.
13. Birthplace Va

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Fannie F. Dooms
(b) Address 3636 Hennick Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 7 1946 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Forest Ave.

18 (a) Funeral director A. Lancaster & Son
(b) Address 2605-11 Eastern Ave.

19 DEC 7 1946 (b) Huntington Williams, M.D. Registrar
Date received by Local Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5, 1946, at 1½ M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1946 to Dec 5 1946. and that I last saw him alive on Dec 5 1946.

| | Duration |
|---|---|
| Immediate cause of death: Uremia | |
| Due to: Hypertension | |
| Due to: Cardio vascular disease | |
| Due to: Renal tuberculosis | 18 |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury SISCOVICK

23. Signature Milton Siscovick M. D.
Address 1 & 29 W Fayette Date signed 12/5/46.

6241

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 194a

Registered No. C16241

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2908 Baker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 Baker St. 16
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** THOMAS BLAINE CONAWAY

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. | 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|---|---|
| none | 213-09-4761 | Male | White | Married |

6 (b) Name of husband or wife Helen F. Conaway
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 5 | 7 | hr. min. |

9. Birthplace Savage, Howard Co., Md.
(Town, county, and state)
10. Usual Occupation Shoe salesman
11. Industry or business

FATHER
12. Name Evan T. Conaway
13. Birthplace A. A. Co., Md.

MOTHER
14. Maiden Name Josephine Keifer
15. Birthplace Pa.

16 (a) Informant Mrs. Helen F. Conaway
(b) Address 2908 Baker Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/46 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd Cem.
Location Ellicott City, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (Date rec'd by registrar) DEC 7 - 1946 Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 6, 1946, at 4:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 9, 1944 to Dec. 6, 1946 and that I last saw him alive on Jany. 24, 1946

Immediate cause of death Coronary Thrombosis — Duration [redacted] Immediate

Due to Previous Coronary Thrombosis — 2 yrs

Due to Arteria - Sclerosis with Hypertension — 3 yrs +

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice E. Shamer M. D.
Address 3300 W. North Ave. Date signed 12/7/46

V S 150

G46242

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1310

Registered No. G46242

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5106 St. George's Ave.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5106 St. George's Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARY C. (MAE) PIPITONE

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | married |

6 (b) Name of husband or ~~XXX~~ Jerome Pipitone
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 18, 1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 yrs. | 7 | 16 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Florist Business
11. Industry or business

FATHER
12. Name Francis J. Woods
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Ballman
15. Birthplace Germany

16 (a) Informant Mr. Jerome Pipitone - husband
(b) Address 5106 St. George's Avenue

17 (a) Burial (b) Date thereof 12/9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Edmondson Ave.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison St.,

19 (a) DEC 7 - 1946 (b) Entered for Williams
(Date rec'd by registrar)

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 12-4- 19 46, at 10 30 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 1935 to 12-4- 1946 and that I last saw h[illegible] alive on 12-4-46 19

| Immediate cause of death | Duration |
|---|---|
| Cardiac dilatation, acute | 4 hrs |
| Due to Hypertension | 8 yrs |
| Due to Chr. nephritis, interstitial | 10 yrs |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
**23.** Signature E. A. Haywood
Address 115 E Eager Date signed 12/6/46

G46243

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1640

G46243
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 [illegible] Alley Carroll Co.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Calvin EARL ~~Hauschboth~~ GORSCHBOTH
(b) If veteran, name war
(c) Social Security Account No.

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
(b) Name of ~~husband~~ or wife Dolores (nee Dietrich)
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 4, 1920
8. AGE: Years 26 | Months 6 | Days 1 | If less than one day hr. min.
9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Apprentice Baker
11. Industry or business
12. Name Edward Gorschboth
13. Birthplace Baltimore, Md.
14. Maiden Name Carolina Baumgardner
15. Birthplace Baltimore, Md.
16. (a) Informant Edward M. Gorschboth - brother
(b) Address 1510 N. Rose St.,
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/46 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Loudon Park
Location 3445 Frederick Ave. Balto. Md.
18. (a) Funeral director Charles E. Schimunek
(b) Address 2001-03 E. Madison Street
19. (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-5- 1946, at 12:30 a M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation by hanging

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/5/46 at 12 M. M.
(b) Where did injury occur? 806 Mc Clean Ct.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury. Hanged by apron cloth tied around neck

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12/5/46

VS 131

16244

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G16244 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 720 N. Port St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 720 N. Port St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** JOSEPH VOKRAL

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Mary (nee Pavlik)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 yrs. | 9 | 18 | hr. min. |

9. Birthplace Czechoslovakia
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Charles Vokral
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name unknown
15. Birthplace Czechoslovakia

16 (a) Informant Mrs. Mary Vokral - wife
(b) Address 720 N. Port St.

17 (a) Burial (b) Date thereof 12/7/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

DEC 7 1946 (b) for Williams M.D.
(Date received by Registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH DEC 4 1946 at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1946 to Dec 4 1946
and that I last saw him alive on Dec 4 1946

Immediate cause of death

| | Duration |
|---|---|
| Due to Coronary Occlusion | Dec 4 |
| Due to Chr Myocarditis | Jan. 1 |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Roarke
Address 801 N. Kenwood Ave Date signed 12/5/46

VS 150

16245

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G16245 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 N. Clinton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Agnes E. Wehner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Late John Leo Wehner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1886

8. AGE: Years 60 | Months 7 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation housewife at home

11. Industry or business

FATHER
12. Name Michael Feehley
13. Birthplace Baltimcre, Md.

MOTHER
14. Maiden Name Louise Smith
15. Birthplace Baltimcre, Md.

16 (a) Informant Elizabeth Adams (sister)
(b) Address 512 North Clinton Street.

17 (a) Burial (b) Date thereof 12/10/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave.

18 (a) Funeral director Charles E. Schimunek.
(b) Address 2601-05 E. Madison Street.

19 (a) DEC 7 - 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 12/6/46 19.., at 9 A. M

**21.** I certify that death occurred on the date above stated: that I attended deceased from 12.3 1946 to 12.6 1946.
and that I last saw h[illegible] alive on 12/5 1946.

Immediate cause of death Cardiorespiratory failure

Due to Cerebral Hemorrhage

Due to Diabetes Mellitus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23. Signature** [signature] M. D.

Address [illegible] Date signed

VS 150

16246
JL - 106490

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH √46 B

Registered No. 16246

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1327 Mosher St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Clarence Dates

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | Married |

6 (b) Name of husband or wife Ethel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, (1862) 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 (52) | (3)5 | 0 | hr. min. |

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Koester's Bakery

FATHER
12. Name Sam Dates
13. Birthplace ?

MOTHER
14. Maiden Name Martha Dates
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/46 (month) (day) (year)
(c) Cemetery or crematory Lillian, Va
Location Lillian, Va

18 (a) Funeral director Jos. H. Kelson
(b) Address 1303 Eastern Ave

19 (a) DEC 7 - 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4 1946, at 6:30a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29 1946 to Dec. 4 1946, and that I last saw him alive on Dec. 4 1946.

| | Duration |
|---|---|
| Immediate cause of death Carcinoma of Stomach | 6 mo? |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: none obtained

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.
Address Bath City Hosp. Date signed 12/5/46

X

G46247

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. G46247

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address U 571 Laurens St.
(c) Hospital or institution:

14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 571 Laurens St. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME James Owens

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: Lousia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1882

8. AGE: Years 64 | Months 1 | Days 19 | If less than one day: hr. min.

9. Birthplace Balto. Co. Md. (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

12. Name William Owens

13. Birthplace Balto. Co. Md.

14. Maiden Name Matilda Cromwell

15. Birthplace Balto. Co. Md.

16 (a) Informant Laura Jackson

(b) Address 571 Laurens St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/8/46 (month) (day) (year)

(c) Cemetery or crematory Long Green, Md.

Location Md.

18 (a) Funeral director Geo. G. Kelson

(b) Address 1303 Presstman St.

19 (a) DEC 7 - 1946 (Date rec'd by registrar) (b) Huntington Willi... M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-5-46 1946, at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1946, to Dec 5 1946 and that I last saw him alive on Dec 5 1946.

| Immediate cause of death | Duration |
|---|---|
| Cerebral hemorrhage | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julian S. White M. D.

Address 1802 Penna. Ave. Date signed 12-6-46

VS 8

16248

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH X 107

G46248 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Dukeland & Rayner Ave
(c) Hospital or institution:
West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7611 Poplar Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Margaret Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) ~~Single~~, married, widowed, or ~~divorced~~. |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13th 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 7 | 22 | hr. min. |

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

**FATHER**
12. Name Wm Lowney
13. Birthplace Md

**MOTHER**
14. Maiden Name Elenora Benner
15. Birthplace Md

16 (a) Informant James Marshall
(b) Address 7611 Poplar Ave

17 (a) Burial (b) Date thereof Dec 9th 1946
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Cedar Hill
Location Ritchie Highway

18 (a) Funeral director Leo S. Cook
(b) Address 1201-03 N. Patterson Park Ave

DEC 7 - 1946
(Date rec'd by registrar) (b) Huntington Hill Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 12-5 1946, at 6.55 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h.c.r. alive on 12-5 1946

Immediate cause of death Pneumonia
Left Lung

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Pneumonia - Left Lung

| Duration |
|---|
| |
| |
| |
| |
| |
| |
| yrs |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Berkowitz M. D.
Address WBGH Date signed 12-5-46

VS 180

X

G16249

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G16249

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 4 S

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 N. Milton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Kearney

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

(b) Name of husband or wife James Kearney (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2nd 1898

8. AGE: Years 48 | Months 7 | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace Wilkesbarre Pa. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name James Mc Guire

13. Birthplace Ireland

14. Maiden Name Mary Mc Donough

15. Birthplace Ireland.

16 (a) Informant James Kearney

(b) Address 1806 N. Milton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 9th 1946 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director Leo G. Leeds

(b) Address 1701-03 N. Patterson Park Ave

(a) DEC 7 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 4, 1946, at 11 50 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of uterus with metastases to paraaortal lymph-nodes; with erosion of carcinoma in Thoracic lymph-nodes through esophageal wall to produce massive esophageal hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 12-5-46

VS 151

16250

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

47a

Register No. G16250

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 197 days
(e) Length of stay in Baltimore (yrs., mos., or days) 197 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State NY (b) County
(c) City or town New York
(If outside city or town limits, write RURAL and give town)
(d) Street No. 91 South St.
(If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Neira, Jose

3 (b) If veteran, name war

3 (c) Social Security Account No. 086-16-4031

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 49 | 11 | 29 | hr. min. |

9. Birthplace ? Spain
(Town, county, and state)
10. Usual Occupation Engine room
11. Industry or business Seafarer

FATHER
12. Name Antonio Neira
13. Birthplace Spain

MOTHER
14. Maiden Name Maria ?
15. Birthplace Spain

16. (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial-Removal (Burial, cremation, or removal) (b) Date thereof 12/11/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location New York, N. Y.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 DEC 7 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6 1946, at 2:37 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 23 1946 to Dec. 6 1946, and that I last saw him alive on Dec. 6 1946.

Immediate cause of death Carcinoma of larynx — Duration 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none done

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Glen E. Ogden
Glen E. Ogden, Surgeon
Address US Marine Hospital, Balto., Md. Date signed 12/7/46

VS 150

X

G46251

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G46251

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Prince George
(c) City or town Laurel
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME John Coon
(b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single
(b) Name of husband or wife Single
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23, 1932

| AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 14 | 10 | 13 | hr. min. |

8. Birthplace Laurel Maryland, Rural
(Town, county, and state)
9. Usual Occupation Student
10. Industry or business

12. Name Rudyrd L. Coon
13. Birthplace Laurel, Maryland
14. Maiden Name Gladys Robey
15. Birthplace Laurel, Maryland
16 (a) Informant Mrs. Gladys Coon
(b) Address Laurel, Maryland
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/46 (month) (day) (year)
(c) Cemetery or crematory Emmanuel Cem
Location Scaggsville, Md.
18 (a) Funeral director D. Witt Donaldson
(b) Address Laurel Cem.
19 (a) DEC 10 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1946, at 7:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy performed at University Hosp. Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Life death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Massive pulmonary hemorrhage

Due to Clostridium Welchii Infection + Shotgun wound of left.

Other Conditions Thigh. Gangrene of the right leg
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 29, '46 at 11:00 A.M.
(b) Where did injury occur? Laurel, Prince Geo. Co. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? On woods While at work? Hunting
(d) Means of injury Firearms - shotgun

23. Signature Howard J. Mullis M.D.
Medical Examiner.
Date signed 12-7-46

VS 151

16252

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. G46252

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 West Read Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME Frances J. Goldsborough

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

(b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17 1906

8. AGE: Years 40 | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

12. Name Mathew Tilghman Goldsborough
13. Birthplace Talbott Co, Md
14. Maiden Name Fannie Johnston
15. Birthplace Talbot Co. Md.

16 (a) Informant Mrs. Bena T. Goldsborough
(b) Address 903 Cathedral St

17 (a) Burial (b) Date thereof Dec 7 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Spring Hill Cem
Location Easton, Md.

18 (a) Funeral director Henry W. Jenkins & Son
(b) Address Mc Culloh & Cathedral Sts.

DEC 7 - 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 6, 1946, at M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12-7-46

VS 191

16253

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 136

Registered No. G46253

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2907 Benson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2907 Benson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Gundert

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widower |

6 (b) Name of husband or wife: Late Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1868.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 4 | 11 | hr. min. |

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation Retired Upholsterer
11. Industry or business B. & O. R. R.

FATHER
12. Name Gundert
13. Birthplace Austria

MOTHER
14. Maiden Name Unknown
15. Birthplace Austria

16 (a) Informant Mrs. Katherine Fischer
(b) Address 2907 Benson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 9/46. (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Harry H. Ritzfeld
(b) Address 4101 Edmondson Ave.

DEC 7 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6/46. 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1946 to Dec 6 1946, and that I last saw him alive on 12-3-46 19

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia | 3 days |
| Due to Pulmonary tuberculosis | unknown |
| Due to | |
| Other Conditions Chronic bronchitis, chronic myocarditis | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Ramin M. D.
Address 206 S. Gilmor St. Date signed 12-7-46

VS 150

16254

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 147a

Registered No. G16254

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution:
Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County —
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 421 Canton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** FRANK NEWCOMER

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife Catherine J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-10-79

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 5 | 26 | hr. min. |

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Robt. Newcomer
13. Birthplace
14. Maiden Name Josephine Hoffman
15. Birthplace

16 (a) Informant RICHARD L FAIT
(b) Address McKees Port Pa
17 (a) Burial (b) Date thereof 12/8/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory McKeesport
Location McKeesport Pa
18 (a) Funeral director Milton Cook Jr
(b) Address 1219 E. 22nd St
19 (a) DEC 7 1946 (b) Huntington W. Va.
(Date rec'd by Local Reg.) (Registered No.)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 7 1946, at 5 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 14 1946, to Dec. 7 1946 and that I last saw him alive on Dec. 7 1946.

| Immediate cause of death | Duration |
|---|---|
| Metastatic Carcinoma | |
| Due to Carcinoma of Sternum | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Metastasis to lungs

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature James O'Hara M. D.
Address Mercy Hosp. Date signed 12-7-46

VS 150

G46255

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G46255

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: Us Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 days
(e) Length of stay in Baltimore (yrs., mos., or days) 38 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Pa. (b) County
(c) City or town Upper Darby (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Copley Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Cavender, Robert Clarence

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| — | ? |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1924

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 22 | 4 | 13 | hr. min. |

9. Birthplace Philadelphia, Pa. (Town, county, and state)
10. Usual Occupation fireman
11. Industry or business Seafarer

FATHER
12. Name Norman Cavender
13. Birthplace Ohio

MOTHER
14. Maiden Name Mary Eliza. Ramsey
15. Birthplace Pa.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof DEC 7 46 (month) (day) (year)
(c) Cemetery or crematory Mt Moriah Cem
Location Philadelphia
18 (a) Funeral director William Cook Sons
(b) Address 1217 St Paul St
19 (a) (Date rec'd by registrar) DEC 7 1946 (b) Huntington Williams registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7 1946, at 5:33 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 30 1946 to Dec. 7 1946 and that I last saw h im alive on Dec. 7 1946

Immediate cause of death Endocarditis bacterial — Duration UNKNOWN
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 12/7/46

VS 150

G46256

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1137a

G46256 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 617 N. Amer Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** James Coutts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-23-66

8. AGE: Years 79 | Months 0 11 | Days 14 | If less than one day hr. min.

9. Birthplace Scotland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name William Coutts
13. Birthplace Scotland

MOTHER 14. Maiden Name May Taylor
15. Birthplace Scotland

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof DW 7/4/6 (month) (day) (year)
(c) Cemetery or crematory Oakwood Cemetery Richmond Virginia
Location

18 (a) Funeral director William Cook Inc
(b) Address 217 E. Paul St.

19 (a) (Date rec'd by registrar) (b) Funeral Director for Williams, Mgr. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 7 1946 at 7 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13 1946 to Dec 2 1946 and that I last saw h alive on Dec 7 1946

Immediate cause of death: Anuria — Duration:

Due to: Post operative

Due to:

Other Conditions: T

(Include pregnancy within 3 months of death)

Date of operation 12/5/46

Major findings of operation: Benign prostatic hypertrophy

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Peter L. Scardina M. D.
Address Johns Hopkins Date signed 12-7-46

VS 150

G46257

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH √83a

G46257

Reg. Dist. No. .....

CE OF DEATH Baltimore City
2412 W Lafayette Ave Balt Md
(If outside city or town limits, write RURAL and give nearest town)
4 Yr
above place of death?
stitution, or street address where death occurred:
May 30 - 1871
n hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2412 W. Lafayette Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

ULL NAME Miss Emma Katherine Myers

3. (b) Social Security Number

| 4. Color or race | 5.(a) Single, married, widowed, or divorced |
|---|---|
| W | Single |

e of husband or wife —

5.(c) If alive, give age — years

ce of d (mo., day, yr.) 5/30/1871

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 6 | 7 | hrs. min. |

Carroll Co
(Town, county, and state)

occupation Labor

ry or business

ame Joseha Myers

irthplace Carroll Co Md

aiden name Anna Bridhead

irthplace Maryland

ent Mr Amos Knight

2412 W Lafayette Ave Balt

Burial Date thereof Dec 16-46
(month) (day) (year)

y or crematory Silver Spring Cemetary

Silver Spring Md

al director Raymond F Knight

Union Bridge Md

1946 [illegible] Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 1946 at 5:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 10 1946, to Dec 7 1946 and that I last saw h— alive on Dec 7 1946

Immediate cause of death Cardiac Asthenia — DURATION 6 hrs

Due to Aortic Sclerosis — 8 mo.
Hemorrhage Cerebral — 8 mo

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E W Koons M. D. or other

Address 1202 St Paul St Date signed 12/7/46

G46258

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G46258 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3817 Clifton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-8
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3817 Clifton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** KATHERINE G. WEIL

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife: Herman Moritz Weil
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 2 | 2 | hr. min. |

9. Birthplace East New Market, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles E. Reed
13. Birthplace England

MOTHER
14. Maiden Name Mary Elizabeth Rawlings
15. Birthplace Maryland

16 (a) Informant Mrs. Beatrice Weil Goldstone
(b) Address 3813 Clifton Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/8/46 (month) (day) (year)
(c) Cemetery or crematory Grandview Cem.
Location Beaver Falls, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) [illegible] Registrar (Date rec'd by registrar)

DEC 8 1946

V S 150

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH Dec. 6, 1946, at 11:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to 12-6-1946 and that I last saw h[illegible] alive on 12-6-1946.

| Immediate cause of death | Duration |
|---|---|
| Coronary occlusion | 1 day |
| Due to Generalized Arteriosclerosis | 10 yrs. |
| Due to | |
| Other Conditions Diabetes Mellitus | 10 yrs. |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 2424 Eutaw Place Date signed 12-7-46

94a

G46259

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓168

G46259 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1354 Cleveland St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME Nancy Johnson

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Sep.

(b) Name of husband or wife

6 (c) If alive, give age years

Birth date of deceased (mo., day, yr.) 11/4/1898

| AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 48 | 1 | 0 | hr. min. |

Birthplace North Carolina
(Town, county, and state)

9. Usual Occupation Domestic

10. Industry or business

12. Name James Edwards

13. Birthplace NC

14. Maiden Name Annie Bow

15. Birthplace NC

(a) Informant Mrs Florence Overton

(b) Address Pair Tree Rd Elizabeth City

(a) Burial (Burial, cremation, or removal) (b) Date thereof 12/8/46 (month) (day) (year)

(c) Cemetery or crematory: Location Elizabeth City N.C.

(a) Funeral director Elroy O Wilson

(b) Address 1000 Brantly ave

12/8 1946 (Date rec'd by registrar) (b) Lexington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-4- 1946, at 6 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Intracranial hemorrhage
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death fill in the following:
(a) Date of injury 12-4-46 at approx. 5 p. M.
(b) Where did injury occur? 1354 Cleveland St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury blunt force
23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 12/5/46

VS 151

G46260

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 55E

G46260 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MARYLAND (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 318 LORRAINE AVE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** MELVIN LEROY PARSONS JR.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | WHITE | SINGLE |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOVEMBER 28, 1940

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 6 | 0 | 15 | hr. min. |

9. Birthplace MARYLAND
(Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name MELVIN LEROY PARSONS, SR.
13. Birthplace BALTIMORE, MARYLAND

MOTHER
14. Maiden Name CATHERINE BALLINGER
15. Birthplace BALTIMORE, MARYLAND

16 (a) Informant HOSPITAL RECORDS AT
(b) Address UNION MEMORIAL HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof DEC 9-46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn Md

18 (a) Funeral director Williams Undertaking Co
(b) Address 1217 E. Fort Ave Street

19 (a) (Date rec'd by registrar) Huntington Williams M.D.

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** DECEMBER 6 1946, at 9 50 PM

**21.** I certify that death occurred on the date above stated; that I attended deceased from DEC 1 1946, to DEC 6 1946, and that I last saw h/M alive on DEC 6 1946

Immediate cause of death LYMPHOSARCOMA — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature Lorraine H. Young M. D.
Address Union Memorial Hosp. Date signed 12/6/46

VS 150

G46261

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46261

Registered No. 146a

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Frederick
(c) City or town Frederick
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 Lee St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Black | Married |

6 (b) Name of husband or wife Nancy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-10-71

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 3 | 27 | hr. min. |

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name John Williams
13. Birthplace Md

MOTHER 14. Maiden Name Sarah Smith
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-10-46 (month) (day) (year)
(c) Cemetery or crematory Fairview Cem.
Location Frederick, Md.

18 (a) Funeral director M. R. Etzler & Son
(b) Address 1086 Church St.

19 (a) (b)
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 7 1946 at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 18 1946 to Dec 7 1946, and that I last saw h[illegible] alive on Dec. 7 1946

Immediate cause of death Carcinoma of the esophagus — Duration 26 mos.?
Due to
Due to
Other Conditions Arteriosclerosis, generalized
(Include pregnancy within 3 months of death)
Date of operation December 6, 1946
Major findings of operation: Carcinoma of esophagus
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State).
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bruce J. Fraser M. D.
Address Johns Hopkins Hosp. Date signed 12-7-46

VS 150

G46262

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 520

G46262 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Greenspring & Belvedere Aves.
(c) Hospital or institution:
Levindale Hebrew Home & Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
Street No. Greenspring Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** BENJAMIN GOLDSTEIN

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife Rosa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Eli
13. Birthplace Poland

MOTHER
14. Maiden Name Betty
15. Birthplace Poland

16 (a) Informant Louis Fried
(b) Address Temple Gordon Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-8-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Gerron Hill Rd

18 (a) Funeral director Jack Lewis Inc.
(b) Address 1439 E. Baltimore St.

19 (a) [illegible] (b) Lillington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12-6 1946 at 7 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1941 to 12-6 1946 and that I last saw h[illegible] alive on 12-6 1946

Immediate cause of death Tumor of L. Kidney (malignant) — Duration

Due to

Due to

Other Conditions Cerebral arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Nyl M. D.
Address Levindale Home Date signed 12-6-46

VS 150

X

G46263

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 163H

G46263 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1919 Wheeler Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 26yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1919 Wheeler Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sendel Horenstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Samuel -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1870

8. AGE: Years 76 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Home's wife

11. Industry or business

FATHER
12. Name Dave -
13. Birthplace Russia

MOTHER
14. Maiden Name Pesepe -
15. Birthplace Russia

16 (a) Informant Edw. Horen
(b) Address 3812 W. Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-8-46 (month) (day) (year)
(c) Cemetery or crematory United Hebrew Cem
Location Wash. Blvd.

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Baltimore St

19 (a) 1946 Washington Williams M.E.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 1946 at 7.45 A M

21. I certify that I took charge of the remains described above, held an Aug Ed Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Test death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to illuminating Gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Dec 6 1946 - 6 50 M.
(b) Where did injury occur? 1919 Wheeler Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? -
(d) Means of injury Open burners on gas Stove

23. Signature William J. Gilmore M.D. Medical Examiner
Date signed Dec 6 - 1946

VS 151

G46264 BC# G50688 G46264

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 108

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution Sinai Hospt.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4938 Edgemere Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** BABY JACK KALMAN DANNENBERG

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | S. |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 4, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 5 | 3 | hr. min. |

9. Birthplace BALTO MD (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name SAMUEL
13. Birthplace RUSSIA

MOTHER
14. Maiden Name MARION
15. Birthplace RUSSIA

16 (a) Informant HOSPT RECORDS
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-8-46 (month) (day) (year)
(c) Cemetery or crematory BETH TFILOH
Location WINDSOR MILL RD

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO. ST

19 (a) (Date rec'd by registrar) (b) Huntington Hills

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-7 1946 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/6/1946 to 12/7 1946 and that I last saw him alive on 12/7/1946.

Immediate cause of death Cerebral Hemorrhage

Due to ?

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Cerebral Hemorrhage

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene O. Goodale M. D.
Address Sinai Hosp Date signed 12/7/46

VS 150

83a

G46265

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH √95c

G46265 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3227 Cotton Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3227 Cotton Place
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

(a) FULL NAME Dollie Ann King

(b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

(b) Name of husband or wife William S King
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, (1875) 1886

8. AGE: Years 61 | Months 5 | Days 27 | If less than one day — hr. — min.

9. Birthplace Madison County, Va
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business —

12. Name William Lewis

13. Birthplace Virginia

14. Maiden Name Fannie Breeden

15. Birthplace Virginia

16 (a) Informant Robert King

(b) Address 2091 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 9/46 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Balto Co Md

18 (a) Funeral director Wilmot Funeral Home

(b) Address 2006 Orleans St

DEC 8 1946 (Date rec'd by local reg.) (b) Huntington Woods Maryland

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 1946, at 1145 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1946, to Dec 7 1946, and that I last saw h[illegible] alive on Dec 6 1946.

Immediate cause of death Pulmonary edema — Duration 2 Mos

Due to Cardiac Decompensation 1 yr.

Due to Arteriosclerosis ?

Other Conditions —

(Include pregnancy within 3 months of death)

Major findings:
Of operations —

Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Keith W. Kartman M.D.

Address 3700 Park Heights Ave Date signed Dec 7 1946

VS 2

G46266

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 51B

G46266 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 806 N. Streeper St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 N Streeper St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Edward Sterling

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Anna Sterling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 23-1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 9 | 13 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Cabinet Maker
11. Industry or business

FATHER
12. Name Edw Sterling Sr
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Bissinger
15. Birthplace Baltimore

16 (a) Informant Mrs. Anna Sterling
(b) Address 806 N. Streeper St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 9. 1946 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) 1946 (Date received by registrar) (b) [illegible] Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 1946 at 10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1946 to Dec 6 1946, and that I last saw him alive July 6 1946.

Immediate cause of death Hypostatic Pneumonia — Duration 12/5/46
Due to
Due to Carcinoma of Prostate — 6-46
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William L. Rydauer M. D.
Address 501 N Eutaw St Date signed 12/6/46

JL - 106400 G46267

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G46267 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 Denham Circle
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Marie Ryan

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | Sep. |

6 (b) Name of husband or wife Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 3 | 8 | hr. min. |

9. Birthplace A. A. Co., Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Basil Queen
13. Birthplace Md.

MOTHER
14. Maiden Name Lizzie
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12-8-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A-A. Co. Md.

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) (b)
(Witnessed by registrar) Registrar

1946
VS 150 Huntington Williams, MD

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12-5 1946, at 7.20A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1946, to Dec. 5 1946, and that I last saw her alive on Dec. 5 1946.

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia & Atelectasis. | |
| Due to Congestive Ht. Failure. | |
| Due to Hypertensive C-V Disease. Myocardial Fibrosis | |
| Other Conditions Scleroderma - Generalized | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: See above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Herbert A. Faber M. D.
Address Balto City Hosps Date signed 12-5-46

X

G46268

CWK-105868

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

46 B

G46268 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 97- 8- 18-

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 N. Mount Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Nancy Roberts, ~~Mrs~~

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | Widowed |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17 - 1849

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 97 | 8 | 18 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housemaid
11. Industry or business

FATHER
12. Name ? Louis Carson
13. Birthplace Prince Geo. Co. Md.

MOTHER
14. Maiden Name Margaret James
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 8, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Geo. H. Stulland
(b) Address 1631 Druid Hill Ave

19 (a) 1945 (Date filed by registrar) Hamilton Williams, Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 5 1946, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6 1946 to Dec. 5 1946, and that I last saw h. er alive on Dec. 5 1946.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Bronchopneumonia & Lobar pneumonia | |
| Due to | |
| Other Conditions Generalized arteriosclerosis | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Bronchio-lobar pneumonia, bilateral

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Dougl Waldron M.D.
Address B C H Date signed 12/6/46

VS 150

G46269

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 467

G46269 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2139 W. Fayette St.
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County ----------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2139 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? ----- (Yes or No)
If yes, name country -----

**3 (a) FULL NAME** Edgar P. Ruckle

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| ---------- | ---------- |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name ####### wife Frances Mulcahey
6 (c) If alive, give age ---years

7. Birth date of deceased (mo., day, yr.) 9/26/1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 2 | 9 | -- hr. -- min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business ----------

FATHER
12. Name William T. Ruckle
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Anne Sieselberger
15. Birthplace Maryland

16 (a) Informant Mrs. Frances M. Ruckle
(b) Address 2139 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/46 (month) (day) (year)
(c) Cemetery ####### New Cathedral
Location Baltimore

18 (a) Funeral director H. H. Mears and Son
(b) Address 805 N. Calvert St.

19 (a) 1946 (b) [illegible] Washington Williams
(Date received by registrar) (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5, 1946, at 10 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 30 1946, to Dec 5 1946, and that I last saw him alive on Dec 5 1946.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Edema | 24 hr. |
| Due to Carcinoma Lung (Metastatic from Bowel) | 3 mo. |
| Due to Cachexia Carcinomatosa Recta | 2 yrs. |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [signature]
Address 1933 W. Balto. St Date signed 12/7/46

VS 150

A 35478 BCA G46270
G46270 F81778

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 14

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County A. A.
(c) City or town Odenton
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 Oakwood Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stephen Marchale - Jr.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-4-43

8. AGE: Years 3 | Months 4 | Days 32 | If less than one day ... hr. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Stephen Marchale
13. Birthplace Penn.

MOTHER 14. Maiden Name Margaret Smith
15. Birthplace Ireland

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 9, 1946 (month) (day) (year)
(c) Cemetery or crematory Our Lady of the Field
Location Millersville Md.

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie Md.

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6, 1946, at 3 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1946 to Dec 6 1946 and that I last saw h Live alive on Dec 6 1946.

Immediate cause of death Increased intracranial pressure; Coma — Duration 2 days

Due to

Due to Brain tumor — Duration ... yrs

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the causes to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Calvin J. Sheldon M. D.
Address Date signed

VS 150

G46271

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G46271 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Belvedere Ave
(c) Hospital or institution: Aged Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 7 12
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Longwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** GERTRUDE BROWNSTEIN

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 65 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Not Known

13. Birthplace Germany

MOTHER 14. Maiden Name Not Known

15. Birthplace Germany

16 (a) Informant Hospt Records

(b) Address

17 (a) Burial (b) Date thereof 12-8-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greenlawn
Location Plot 14 Lot 6 Hamilton Ave

18 (a) Funeral director Jack Levin Inc

(b) Address 1439 E. Balto St

19 (a) (b)
(Date received by registrar) Huntington Williams Registrar

12-8-1946

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-8 1946 at 7 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-17 1946 to 12-8 1946 and that I last saw h[illegible] alive on 12-8 1946.

Immediate cause of death Chronic Cardio vascular disease — Duration

Due to — Duration

Due to — Duration

Other Conditions Pulmonary infarction — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Ryel M. D.

Address Levindale Home Date signed 12-9-46

X

G46272 G46272

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18 N. Pearl St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 18 N. Pearl St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha R. Purdy
(b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. W.
(b) Name of husband or wife
6 (c) If alive, give age 1876 years
7. Birth date of deceased (mo., day, yr.) July 5- 1876
8. AGE: Years 70 (72) Months 5 Days 2 If less than one day hr. min.
9. Birthplace Hagerstown Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —
12. Name William W. Poward
13. Birthplace Hagerstown Md
14. Maiden Name Ada Kershner
15. Birthplace Hagerstown Md
16 (a) Informant Hazel A. Pierce
(b) Address 7649 Woodbury Rd. Wash. D.C.
17 (a) Burial (b) Date thereof 12-9-1946 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Rose Hill
Location Hagerstown Md.
18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Eight St.
19 (a) Washington Williams, Registrar
(Signature of registrar)
1946
VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 1946 at M
21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1936 to Dec 7 1946
and that I last saw her alive on Dec 5 1946

| Immediate cause of death | Duration |
|---|---|
| Coronary disease with Myocardial degeneration | |
| Due to | |
| Due to | |
| Other Conditions albuminuria Morphine addiction | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Vernon H. Howard M. D.
Address Church Home & Hospital Date signed 12-9-46

G46273

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 195E

G46273 Registered No.

**PLACE OF DEATH:**
) Baltimore City, Maryland
) Street address Raynor and Dukeland
) Hospital or institution West Baltimore General Hospital
) Length of stay in hospital or inst. (yrs., mos., or days) 39 days
) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (or county)
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 517 N. Brice St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME Warren J. Hurdle

(b) If veteran, name war

3 (c) Social Security Account No. 220-72-9774

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

(b) Name of husband or wife

6 (c) If alive, give age — years

Birth date of deceased (mo., day, yr.) 23-Aug-1926

| AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 20 | 3 | 13 | hr. min. |

Birthplace Baltimore, Maryland (Town, county, and state)

Usual Occupation Western Electric Co

Industry or business

12. Name Edgar L. Hurdle

13. Birthplace Washington D.C.

14. Maiden Name Florence L. Brown

15. Birthplace Washington D.C.

(a) Informant Edgar L. Hurdle

(b) Address 517 N. Brice Street

(a) Burial (Burial, cremation, or removal) (b) Date thereof 9 Dec 46 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore, Md.

(a) Funeral director C. B. Hilpert & Son

(b) Address 300 Eutaw Place

(a) (b)
(Date received by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 6 Dec 1946, at 6:07 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 27 Oct 1946, to 6 Dec 1946, and that I last saw him alive on 6 Dec 1946.

| | Duration |
|---|---|
| Immediate cause of death: Respiratory Failure | 1 hr. |
| Due to: Posterior Dislocation of 5th Cervical Vertebra on 6th w/a | 39 days |
| Due to: compression of spinal cord, Paralyzed below shoulders | 39 days |
| Other Conditions: Fracture of body of 5th Cervical Vertebra | |
| (Include pregnancy within three months of death) | |
| Date of operation: | |
| Major findings of operation: | |
| of autopsy: | |

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 16/8
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 27 Oct '46 at 4 P.M.
(c) Where did injury occur? on a Sandlot in West Balto. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Football Field (Specify type of place) While at work? No
(e) Means of injury Football Play - athletics
23. Signature J. W. Bell M.D.
Address West Balto Gen Hosp Date signed 6 Dec '46 M. D.

For S. McStaffrick by Howard D. Mercer, M.D.

VS 190

G46274

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 160

G46274 Registered No.

**PLACE OF DEATH:**
1) Baltimore City, Maryland
2) Street address 4407 Adelle Terrace
3) Hospital or institution:
St. Agnes Hospital
4) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
5) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4407 Adelle Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME Frank K. J. Katzenberger

(b) If veteran, name war

3 (c) Social Security Account No.

| Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widowed |

(b) Name of husband or wife Lillian C.
6 (c) If alive, give age 8 years

Birth date of deceased (mo., day, yr.) 30 July 1866

| AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 5.4 | 8 7 | hr. min. |

Birthplace Baltimore, Md.
(Town, county, and state)
Usual Occupation Retired.
Industry or business

12. Name Louis Katzenberger
13. Birthplace Germany
14. Maiden Name Mary Mallon
15. Birthplace Ireland

(a) Informant Dr. Norbert Nitsch
(b) Address 4407 - Adelle Terrace
(a) Burial (b) Date thereof 10/Nov./46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.
(a) Funeral director F. B. Shubert & Son
(b) Address 1300 Eutaw Place

(a) 1946 (b)
(Date rec'd by registrar) Livingston Williams, Registrar

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/7/1946, at 3 40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
3rd and 4th degree burns - 95% of body
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 28-4
(a) Date of injury 12/7/46 at about 3 40 P.M.
(b) Where did injury occur? 4407 Adelle Terrace
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Accidental fire at home

23. Signature C. P. Jelenko M.D.
Medical Examiner.
Date signed 12/7/46

G46275

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 95B

Registered No. G46275

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 W. Pratt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 W. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George J. Reuschling

(b) If veteran, name war None

3 (c) Social Security Account No. 213-05-9624

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

(b) Name of husband or wife Catherine M.

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Feb 14 1903

8. AGE: Years 43 Months 9 Days 22 If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county and state)

10. Usual Occupation Checker

11. Industry or business American Oil Co

12. Name of Father Wm Reuschling

13. Birthplace Balto Md

14. Maiden Name of Mother Carrie Tillman

15. Birthplace Balto Md

16 (a) Informant Catherine M. Reuschling

(b) Address 1708 W. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 9 1946 (month) (day) (year)

(c) Cemetery or crematory London Park
Location City

18 (a) Funeral director Rolf C & B M. Walters

(b) Address Pratt & Stricker Sts.

19 (a) (b) (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 6th 1946, at 5:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945 to Nov. 26 1946, and that I last saw him alive on Dec 6 1946

Immediate cause of death Cardiac decompensation — Duration

Due to Rheumatic heart disease

Due to

Other Conditions Ascites

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry A. Fine M. D.

Address 18 Biscayne Pl Date signed 12/11/46

VS. 150 DEC 9 - 1946 Huntington Williams, M.D.

X

G46276

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 122B

G46276 Registered No.

**PLACE OF DEATH:**

1) Baltimore City, Maryland

2) Street address

3) Hospital or institution: West Balto. Gen Hosp. No

4) Length of stay in hospital or inst. (yrs., mos., or days)

5) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 1807 W. MULBERRY St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

(a) FULL NAME Milton Turner ( MILTON W. TURNER )

(b) If veteran, name war None

3 (c) Social Security Account No. 215-03-7947

Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

(b) Name of husband or wife HELEN M.

6 (c) If alive, give age 78 years

Birth date of deceased (mo., day, yr.) JUNE 18-1907

AGE: Years 39 | Months 5 | Days 19 | If less than one day ____ hr. ____ min.

Birthplace BANNEWICK md (Town, county, and state)

10. Usual Occupation CARPENTER

11. Industry or business CONSTRUCTION FIRM

12. Name JOHN TURNER

13. Birthplace ?

14. Maiden Name JENNIE CRUM

15. Birthplace ?

16 (a) Informant HELEN M. TURNER

(b) Address 1807 W. MULBERRY St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC 10-1946 (month) (day) (year)

(c) Cemetery or crematory LONDON PARK

Location Rolt & B.M. Watson City

18 (a) Funeral director

(b) Address PRATT & STRICKER STS

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 7 Dec 1946, at 3.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 Dec 1946 to 7 Dec 1946 and that I last saw h.[illegible] alive on 7 Dec 1946.

| Immediate cause of death | Duration |
|---|---|
| Cardiac Thrombosis. Failure | |
| Due to Shock. | 9 hrs |
| Due to Intestinal obstruction | 36 hrs |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation 6 Dec 46 Major findings of operation: Intestinal obstruction

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Carl G Wechsler M. D.

Address West Balto. Gen Hosp Date signed 7 Dec 46

FEB 9 - 1946

X

G46277

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83A

Registered No. G46277

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3918 OLD YORK ROAD
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 YEARS

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3918 OLD YORK ROAD (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME JAMES EZRA BOWERS

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOWED

(b) Name of husband or wife: FLORENCE E. MITTEN

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) APRIL 8, 1867

8. AGE: Years 79 | Months 8 | Days 0 | If less than one day hr. min.

9. Birthplace CARROLL COUNTY MD. (Town, county, and state)

10. Usual Occupation RETIRED FARMER

11. Industry or business

12. Name JOSEPH BOWERS

13. Birthplace MD

14. Maiden Name MARGARET BARNHART

15. Birthplace MD

16 (a) Informant MRS MARGERET WATERS

(b) Address 2643 N. CHAS. ST. BALTO. MD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/11/46 (month) (day) (year)

(c) Cemetery or crematory KRIDERS CEMETERY

Location WESTMINSTER, MD.

18 (a) Funeral director JOHN R. BYERS

(b) Address WESTMINSTER, MD.

19 (a) (Date rec'd by registrar) DEC 9 1946 Registrar Huntington

VS

## MEDICAL CERTIFICATION

20. DATE OF DEATH 8 Dec 1946, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 30 ~~Dec~~ NOV. 1946 to 8 Dec 1946 and that I last saw h alive on 19

| Immediate cause of death | Duration |
|---|---|
| Cerebral hemorrhage | 1 week |
| with hemiplegia | |
| Due to Arteriosclerosis | |
| with hypertension | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lloyd E. Saylor M. D.,
Address 3902 Greenmount Ave Date signed 8 Dec. 46

X

G16278

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

46 E

G16278 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4wks.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Borough of Oxford. (If outside city or town limits, write RURAL and give town)
(d) Street No. Chase St. Lincoln Road (If rural give location)
(e) Citizen of foreign country? Yes ? (Yes or No)
If yes, name country

3. (a) FULL NAME Ezalmon Benjamin Ayers
(b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married.
(b) Name of husband or wife: Mrs. Ada W Ayers
6 (c) If alive, give age 59 years
7. Birth date of deceased (mo., day, yr.) Dec. 8 1946 (illegible)
8. AGE: Years 54 Months 6 Days 22 If less than one day: hr. min.
9. Birthplace Hickey (Town, county, state or country)
10. Usual Occupation Blacksmith
11. Industry or business Body builder.
12. Name of father W.T. Ayers.
13. Birthplace of father Hickey Md.
14. Maiden Name of mother Alice M. Ayers.
15. Birthplace of mother Lombard Maryland
16 (a) Informant Wife
(b) Address Oxford. Pa.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-46 (month) (day) (year)
(c) Cemetery or crematory Oxford, Pa.
Location Oxford, Chester Co Pa
18 (a) Funeral director E.C. Rogers
(b) Address Oxford Pa
19 (a) 12-9-1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8th 1946, at 12 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1946 to Dec 8 1946.
and that I last saw h[illegible] alive on 11 45 Dec 8 46
Immediate cause of death Heart failure — Duration
Due to Coronary occlusion and/or pulmonary embolism
Due to possibly abdominal (mesenteric)
Other Conditions thrombophlebitis
Carcinoma ileo-cecal region
(Include pregnancy within three months)
Date of operation 11-25-46
Major findings of operation: Carcinoma of ileo cecal region
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature J.B. Heuniger Jr.
Address Union Memorial Date signed 12/8/46

VS 150 Huntington Williams Md

X Hospital. Maryland.

G46279

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1569

Registered No. G46279

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2208 Eastern ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2208 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin Krawinski

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Anna Krawinski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 1881

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business self

FATHER
12. Name George Krawinski
13. Birthplace Poland

MOTHER
14. Maiden Name Kantor
15. Birthplace Poland

16 (a) Informant Pauline Witkowski
(b) Address 2208 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director F. W. Tyszewski
(b) Address 1930 Eastend Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 9 - 1946

Huntington Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1946 to Dec 6 1946, and that I last saw him alive on Dec 6 1946.

| Immediate cause of death | Duration |
|---|---|
| Aguta cardiac dilatation | 1 day |
| Infectious arthritis | 14 yrs. |
| Due to Senile changes | 3 yrs. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leo A. Lepley M. D.
Address 2121 Calhoun St. Date signed 12/9/46

406510 G16280

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH √61

Registered No. G16280

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6000 Bellona Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Edwin A. Brevington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-14-80

8. AGE: Years 66 | Months 11 | Days 3 | If less than one day hr. min.

9. Birthplace Md (Salisbury)
(Town, county, and state)

10. Usual Occupation — none

11. Industry or business

BURIAL PERMIT

12. Name Henry L. Brevington

13. Birthplace Md (Salisbury)

14. Maiden Name Edwina Hayman

15. Birthplace Md (Somerset County)

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/46 (month) (day) (year)

(c) Cemetery or crematory Parsons'

Location Salisbury, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.

(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) DEC 9 1946 (b) Huntington Williams

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7 1946 at 1 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1946 to Dec 7 1946 and that I last saw h[illegible] alive on Dec. 7 1946

Immediate cause of death Purulent pericarditis, cause undet. — Duration 2 days

Due to Arteriosclerotic heart disease

Due to Arteriosclerosis generalized

Other Conditions Diabetes mellitus with acidosis
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy Purulent pericarditis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Andrew E. Salzgaller M.D.
Address Johns Hopkins Hosp. Date signed 12/7/46

90 B

G46281

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94A

Registered No. G46281

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1520 Shadyside Rd.
(c) Hospital or institution:
none

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 Shadyside Rd.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Bess Davis Cremeans

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| female | white | married |

6 (b) Name of husband or wife Walter R. Cremeans
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 3 | 20 | hr. min. |

9. Birthplace Kentucky
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

**FATHER**
12. Name Charles M. Davis
13. Birthplace Ky.

**MOTHER**
14. Maiden Name Josephine Eberly
15. Birthplace Ky.

16 (a) Informant Rev. Walter R. Cremeans
(b) Address 1520 Shadyside Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/46 (month) (day) (year)
(c) Cemetery Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1946, at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1946 to Dec 6 1946, and that I last saw h.e. alive on Dec 6 1946.

| Immediate cause of death | Duration |
|---|---|
| Coronary Occlusion | 12 Wks. |
| Due to coronary arteriosclerosis | — |
| Due to — | |
| Other Conditions None. | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. F. Clatfoot M. D.
Address 6210 York Road Date signed Dec 9 1946

VS 130 DEC 9 - 1946

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G16283 93D G16283

**PLACE OF DEATH:**
Baltimore City, Maryland
Street address
Hospital or institution: West Balto General Hospital
Length of stay in hospital or inst. (yrs., mos., or days)
Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2706 Sulgrave Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**1. (a) FULL NAME** Herbert A Rhoads

(b) If veteran, name war

3 (c) Social Security Account No.

| Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | widowed |

(b) Name of husband or wife Alexina Guest
6 (c) If alive, give age years

Birth date of deceased (mo., day, yr.) May 21, 1867

| AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 6 | 16 | hr. min. |

Birthplace Baltimore, Md.
(Town, county, and state)

Usual Occupation Antique jewelry
Industry or business

12. Name John Rhoads
13. Birthplace Md.
14. Maiden Name Virginia Poor
15. Birthplace Md.

(a) Informant Mrs. Ethel R. Robins
(b) Address 2706 Sulgrave Ave.

(a) Burial (b) Date thereof 12/10/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery Greenmount
Location Greenmount & Oliver Sts.

(a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1906 Eutaw Place

(a) (b) Huntington Williams
(Date rec'd by registrar) Registrar

VS 151 DEC 4 - 1946

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Dec 7 1946, at 6 40 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Stafford M.D.
Medical Examiner
Date signed Dec 8, 1946

G46283 G46283

BALTIMORE CITY HEALTH DEPARTMENT 94A Lib 178 3

# CERTIFICATE OF DEATH

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 944 Hebb Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 944 Hebb Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Josephine R. Gobe

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Mulat. | Married |

6 (b) Name of husband or wife Joseph D. Gobe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2. 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 6 | 6 | hr. min. |

9. Birthplace Michigan (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

MOTHER FATHER

12. Name (Unknown) Ronsevain
13. Birthplace France
14. Maiden Name Susan (Unknown)
15. Birthplace Canada

16 (a) Informant Joseph D. Gobe
(b) Address 944 Hebb Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1217 E. Pratt St

19 (a) [illegible] (b) Huntington Williams

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8 1946, at 5 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 1946, to Dec 6 1946, and that I last saw h[illegible] alive on 12/6 1946

| Immediate cause of death | Duration |
|---|---|
| Acute Coronary Infarction | |
| Due to Coronary Sclerosis | |
| Due to Chr Myocardial Is | |
| Other Conditions Chr Hemiplegia Diabetes cerebral Hemorrhage | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 733 Ainsworth St Date signed 12/8/46

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

45F

Registered No. G46284

FN. G46284 106270

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harold Chester Johnson

3 (b) If veteran, name war W

3 (c) Social Security Account No. None

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband or~~ wife E Catherine Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 26th 1879

8. AGE: Years 67 | Months 1 | Days 11 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Attorney

11. Industry or business

FATHER
12. Name Jathro
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Galboarth
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records

17 (a) Burial (b) Date thereof 12/11/46
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Bork Inc.
(b) Address 1217 St. Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

P

20. DATE OF DEATH December 7th 1946, at 5.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21st 1946 to Dec. 7th 1946 and that I last saw h im alive on Dec 7th 1946

Immediate cause of death Sudden uncontrollable hemorrhage resulting in shock — Duration

Due to Carcinoma of pharynx with metastasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. H. Gibbs
Address Baltimore City Hosp. Date signed 12/7/46 M D

DEC 9 - 1946

Huntington Williams, M.D.

G46285

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BA

G46285
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St
(c) Hospital or institution: SBGH 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3129 Baker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Tiedeman
3 (b) If veteran, name war
3 (c) Social Security Account No. 212-09-7778

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced M
6 (b) Name of husband or wife Minnie
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 6-24-1890

8. AGE: Years 56 Months 5 Days 14 If less than one day hr. min.
9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Cashier
11. Industry or business C.D. Kenny Co.

FATHER
12. Name Bernard Tiedeman
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Lockman
15. Birthplace

16 (a) Informant Mrs. Minnie Tiedeman
(b) Address 3129 Baker St.

17 (a) Burial (b) Date thereof 12/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md.
18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.
19 (a) (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-8 1946, at 4:30 A M
21. I certify that death occurred on the date above stated, that I attended deceased from 12-2 1946 to 12-8 1946 and that I last saw h. alive on 12-8 1946

| | Duration |
|---|---|
| Immediate cause of death Cerebral Hemorrhage | |
| Due to Ruptured Intracranial Aneurism | |
| Due to Hypertension | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Lloyd Lindell MD
Address 1211 Light Ave Date signed 12-9-46
M.D.
L Lindell

VS 150

DEC 9 1946 Huntington Williams, M.J.

G46286
CWK-106666

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 61

G46286
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Days
68- 6- 17-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 19
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3308 Haywood Avenue (Hayward)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Charles Sauer

3 (b) If veteran, name war

3 (c) Social Security Account No. Spanish-American

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21-1878

8. AGE: Years 68 | Months 6 | Days 17 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired Fireman

11. Industry or business City of Balto.

12. Name John Sauer

13. Birthplace Germany

14. Maiden Name Sophia

15. Birthplace Germany

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/46 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Balto MD

18 (a) Funeral director Wilson & Col Sons

(b) Address 1312 W Pratt St

19 (a) DEC 9 - 1946 (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 8 1946 at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 6 1946 to Dec. 8 1946, and that I last saw him alive on Dec. 8 1946.

Immediate cause of death: Respiratory Failure

Due to: Hypertensive Cardiovascular Disease

Due to: Congestive Failure

Other Conditions: Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. K. Scarborough M. D.

Address Balto. City Hosp. Date signed 12-8-46

VS 150

Huntington Williams, M.D.

93D

G46287

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1164

G46287 Registered No.

**PLACE OF DEATH:**
1) Baltimore City, Maryland
1) Street address
1) Hospital or institution: St. Josephs Hospital
1) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
1) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3325 Kenyon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

(a) FULL NAME Ray - Raymond Hann

(b) If veteran, name war First | 3 (c) Social Security Account No. 212-01-5522

Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

(b) Name of husband or wife Viola Stann

6 (c) If alive, give age years

Birth date of deceased (mo., day, yr.) Apr 5-1899

AGE: Years 47 | Months 8 | Days 2 | If less than one day hr. min.

Birthplace Salem Va - Roanoke City (Town, county, and state)

Usual Occupation Shop Foreman

Industry or business Dirt Repair Shops

12. Name Thomas Stann

13. Birthplace Emmitsburg Md

14. Maiden Name Ida Pearl Shaffner

15. Birthplace Salem Virginia

(a) Informant Ray Stann Jr

(b) Address 3325 Kenyon Ave

(a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 10-46 (month) (day) (year)

(c) Cemetery or crematory Fort Lincoln

Location Maryland

(a) Funeral director J. J. Herr & Son

(b) Address 3091 Kentucky Ave

(a) Dec 9 - 1946 (Date received by Registrar) Huntington Willis, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/7 1946 at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gunshot wound of Head

Due to:

Other Conditions Depression

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 26-3

(a) Date of injury 12/7/46 at about 7:00 P.M.

(b) Where did injury occur? 3325 Kenyon Ave

(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No

(d) Means of injury Bullet from 38 S&W Special C 25 caliber Pistol

23. Signature C. J. Pelosake M.D. Medical Examiner.

Date signed 12/7/46

VS 181

G46288 B.C.H. 64012

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

III C

G46288 Registered No.

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address Caroline + Oliver Sts.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2814 Lake Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary - Catherine Johnson
(b) If veteran, name war
(c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.
(b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/5/46

8. AGE: Years | Months | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

BORN IN FAMILY

12. Name William Johnson
13. Birthplace St Louis Mo.
14. Maiden Name Jessie Thomas
15. Birthplace Upper X Roads.

16 (a) Informant Mary Thomas
(b) Address Eastern Md.

17 (a) Burial (b) Date thereof Dec 10 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodmere
Location Rutledge Harford Co Md.

18 (a) Funeral director Charles E. Kurtz
(b) Address Jarrettsville Md

19 DEC 9 - 1946 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8, 1946, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/5 1946 to 12/8 1946, and that I last saw her alive on 12/8 1946

Immediate cause of death CARDIO - Respiratory Failure — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Slight congestion of lower lobes of lungs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard A. Young M. D.
Address 24 S. Broadway Date signed 12/9/46

Huntington Williamsport Md

G16289

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94A

G16289 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hrs. 50 m.
(e) Length of stay in Baltimore (yrs., mos., or days) 35

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 646 Pitcher
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Warner Hamlette
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Marie Hamlette
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9/22/1892
8. AGE: Years 54 Months 2 Days 14 If less than one day hr. min.
9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name William Hamlette
13. Birthplace Va

MOTHER
14. Maiden Name Haskins
15. Birthplace Va

16 (a) Informant Mrs Marie Hamlette
(b) Address 646 Pitcher St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-10-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore - Md
18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W Biddle St
19 (a) Filed DEC 9 1946 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 6 1946; at 7:50 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 3:15 p.m. 12/6 1946 to 7:50 12/6 1946. and that I last saw h[illegible] alive on 12/6 1946.

| | Duration |
|---|---|
| Immediate cause of death: Myocardial Failure | 4-5 hrs. |
| Due to: Coronary Thrombosis | |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
M. D. Signature George McDonnell
Address 844 N Carey Date signed 12/7/46

VS 150

G46290 | BALTIMORE CITY HEALTH DEPARTMENT | G46290

# CERTIFICATE OF DEATH 1248

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1523 E. Madison St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1523 E. Madison St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Claretta Smith
(b) If veteran, name war
3 (c) Social Security Account No. None
4. Sex Female
5. Color or race Col.
6 (a) Single, married, widowed, or divorced. Married
(b) Name of husband or wife Horace Smith
6 (c) If alive, give age 50 years
7. Birth date of deceased (mo., day, yr.) 4/5/1896
8. AGE: Years 50 Months 8 Days 0 If less than one day hr. min.
9. Birthplace Columbia, S. C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business
12. Name James Brown
13. Birthplace Columbia, S.C.
14. Maiden Name Nora Jenkins
15. Birthplace Columbia S.C.
16 (a) Informant Horace Smith
(b) Address 1523 E Madison St
17 (a) Burial (b) Date thereof Dec 9. 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem
Location Brooklyn Md
18 (a) Funeral director Clara B. Wilson
(b) Address 1000 Brantley ave
19 (a) 1946 (b) [illegible] Williams Registrar
(Date rec'd City registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-5 1946, at 9:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/28 1946 to 12/5 1946 and that I last saw h.s.v alive on 12/3 1946

Immediate cause of death: hypertensive cardiovascular disease

Due to: Cardiac decompensation

Due to:

Other Conditions: Cirrhosis of liver
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: unk.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rayner Browne M.D.
Address 1500 E. Madison St Date signed 12/6/46

Rayner Browne 13-A

G16291 BCH

504725 F9642

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

14

Registered No. G16291

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL 5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Canal Lat-
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Burnell Bell.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-7-44

8. AGE: Years 2 | Months 9 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Herman Bell
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Henderson
15. Birthplace Ma

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Dec 9, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Baltimore, Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1004 Bentley ave

19 (a) Dec 9 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

A

20. DATE OF DEATH Dec. 6 1946, at 2.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 16 1946, to Dec. 6 1946 and that I last saw him alive on Dec. 6 1946

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Tuberculous Meningitis | 3 weeks |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert J. Sheldon M. D.
Address Date signed

VS 150

X

G16292
CWR-88235

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13 B

Registered No. G16292

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 6- 9-
(e) Length of stay in Baltimore (yrs., mos., or days) 42- 1- 20-

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1018 E. Pratt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Amy Neal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Clarence (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15-1904

8. AGE: Years 42 | Months 1 | Days 20 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Charles Jones (D)

13. Birthplace Virginia

14. Maiden Name Fannie Williams

15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof Dec 10. 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location Brooklyn Md

18 (a) Funeral director Chas. O. Wilson

(b) Address [illegible] 1510 Edmondson Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

P

20. DATE OF DEATH December 5 1946, at 3:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1944 to Dec. 5 1946, and that I last saw her alive on Dec. 5 1946.

Immediate cause of death Pulmonary Tuberculosis — Duration 3 years

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph L. Byrd M. D.

Address Balto City Hosps Date signed 12-5-46

Huntington Williams

X

G46293

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94A

G46293 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3600 Parkside Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3600 Parkside Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** LOUISE MARIE GARDNER

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 215-09-1562

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Widow |

6 (b) Name of husband or wife: Frank E. Gardner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 19, 1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | 5 | 16 | hr. min. |

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: August L. Ewald, Sr.
13. Birthplace: Germany

MOTHER
14. Maiden Name: Maria Orth
15. Birthplace: Germany

16 (a) Informant: Mr. Wm. A. Gardner - son
(b) Address: 3600 Parkside Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/46 (month) (day) (year)
(c) Cemetery or crematory: PARKWOOD CEMETERY
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) (Date filed) (b)

DEC 9, 1946 Huntington Hall Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12-5-46 19.., at 4.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1, 1946 to 12-5- 1946 and that I last saw h[illegible] alive on 12-5- 1946

Immediate cause of death: Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Ewald

Address 36 York Court Date signed 12/8/46

G46294

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1118

G46294 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2906 Reisterstown Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2906 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

(a) FULL NAME Ruth Samstag

(b) If veteran, name war

3 (c) Social Security Account No.

Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widow

(b) Name of husband ~~or wife~~ Frank H. Samstag

6 (c) If alive, give age years

Birth date of deceased (mo., day, yr.) Oct. 12, 1874

| AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 1 | 25 | ....hr. ....min. |

Birthplace Phila. Pa.
(Town, county, and state)

9. Usual Occupation None
10. Industry or business

12. Name ? Henrietta
13. Birthplace Baltimore Md.
14. Maiden Name Jane McManus
15. Birthplace Balto. Md.

(a) Informant Mr. Banna Secretary
(b) Address 1842 N. H. - N.E. Washington D.C.

(a) Burial (b) Date thereof 12/9/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~crematory~~ Oheb Shalom
Location Balto. Md.

(a) Funeral director Edward Sonnheim & Son
(b) Address 1902 Eutaw Place

(a) DEC 9 - 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 1946, at 8:36 P M

21. I certify that I took charge of the remains described above, held an Autopsy on Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) How did means of injury occur?

23. Signature William G. Helfrich M.D.
Medical Examiner.
Date signed Dec 7, 1946

VS 151

G46295

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 49A

Registered No. G46295

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 513 S. Belnord Ave
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 513 S. Belnord Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

**3** (a) FULL NAME Theodora Zaslonka

(b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edmond

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Oct 22 1894

8. AGE: Years: 52 | Months: + | Days: 14 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Andrew Golczynski

13. Birthplace Poland

MOTHER

14. Maiden Name Marcyanna Duklas

15. Birthplace Poland

16 (a) Informant Edmond Zaslonka

(b) Address 513 S. Belnord Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/46 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem

Location German Hill Rd.

18 (a) Funeral director John J. Duda

(b) Address 2802 Hudson St

19 (a) DEC 9 - 1946 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 1946, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1946 to Dec 6 1946, and that I last saw h... alive on ... 19...

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of Ovary & generalized metastasis | 5-14-46 |
| Due to | |
| Due to | |
| Other Conditions None | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations As above
Of autopsy None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Zaslonka M. D.

Address 842 S. Exeter St Date signed 12-7-46

VS 2

G46296

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 947

G46296 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Aged Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Greenspring Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME SAMUEL RANKIN
(b) If veteran, name war
(c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

(b) Name of husband or wife Annie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16. (a) Informant Hospital Records
(b) Address

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-9-46 (month) (day) (year)
(c) Cemetery or crematory Wyndon Memorial Park
Location Baltimore

18. (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Baltimore St

19. (a) 12-9-1946 (Date received by registrar) (b) Registrar's No. 41111

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 1946 at 2:17 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-9 1945 to 12-9 1946 and that I last saw h.m. alive on 12-9 1946.

Immediate cause of death: (a) Acute Coronary Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Edmund Reese M.D.
Address Cheverdale Date signed 12/11/46

Huntington

G46297 ✓ G46297

G46297

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

930 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Levendale
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Levendale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME Etta Shapiro

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

(b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Louis

13. Birthplace Russia

14. Maiden Name Minnie

15. Birthplace Russia

16 (a) Informant Isaac Shapiro

(b) Address 2022 Linden Ave

17 (a) Burial (b) Date thereof 12-9-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Sherwood-Herzing Run

Location Jack Kentucky Inc

18 (a) Funeral director

(b) Address 1439 E Balto St

19 (a) (b) 12-9-1946
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-9 1946, at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10 1930 to 12-9 1946, and that I last saw him alive on 12-9 1946.

Immediate cause of death Chr. card. vas. disease.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Levin

Address Levendale Date signed 12/9/46

VS 150

Birth Certificate
G46298
G-64642

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

G46298
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Dukeland & Rayner Ave.
(c) Hospital or institution: W. Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2301 Lauretta Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Robert Alton Helmrich Jr

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | S |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 2 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert Helmrich
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Dolores Adams
15. Birthplace Balto. Md.

16 (a) Informant Robert G. Helmrich
(b) Address 2301 Lauretta Ave

17 (a) Burial (b) Date thereof Dec 9. 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto

18 (a) Funeral director Mrs. John W. Teufel Son
(b) Address 2011 Edmondson Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150 DEC 9 - 1946 Huntington Williamsville, Md

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 8, 1946 at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 P.M., Dec 6, 1946 to Dec. 8, 1946 and that I last saw him alive on Dec. 8, 1946

| | Duration |
|---|---|
| Immediate cause of death Spontaneous Hemorrhage | |
| Due to Hemorrhagic disease of the newborn | |
| Due to | |
| Other Conditions Prematurity (about 27 weeks) | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Same as above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence , at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leon Tobey M.D.
Address West Balto. Gen. Hosp. Date signed 12/9/46

G46299 G46299

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94 A

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Sts
(c) Hospital or institution:
Maryland General Hosp. W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days) —

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3409 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** J. Wayne Hobbs

3 (b) If veteran, name war: none
3 (c) Social Security Account No. no

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife: Bessie Lenoah Hobbs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1904

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 42 | 1 | 8 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Policeman
11. Industry or business Balto. City

FATHER
12. Name Lieut. Stewart Hobbs
13. Birthplace Md.

MOTHER
14. Maiden Name -- Hopkins
15. Birthplace Md.

16 (a) Informant Mr. Kenneth W. Davis
(b) Address 3413 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director MM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

DEC 9 - 1946

VS 15a

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 7th 1946, at 11:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 7th 1946 to Dec. 7th 1946 and that I last saw him alive on Dec. 7th 1946.

| Immediate cause of death | Duration |
|---|---|
| Cardiac Failure | |
| Due to Coronary Thrombosis | 3 min. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Donald Stamm, M.D.
Address Md. Gen. Hosp. Date signed 12/9/46

G46300

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

G46300 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Blackstone Apts
(c) Hospital or institution: Charles & 33rd Sts.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Blackstone Apts. #504
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATHARINE T. KIRWAN

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1884

8. AGE: Years 62 | Months 5 | Days 10 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Exec. Director

11. Industry or business Md. Childrens Aid Society

FATHER
12. Name Albert C. Kirwan
13. Birthplace Md.

MOTHER
14. Maiden Name Mettie Koefoed
15. Birthplace Md.

16 (a) Informant Mrs. A. K. McCoy, sister
(b) Address 5109 Norwood Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12/9/46 (month) (day) (year)
(c) Cemetery or crematory Greenmount Crematory
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

V S DEC 9 - 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6, 1946, at 12 N M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1946 to Dec 6 1946 and that I last saw her alive on Dec 6 1946.

Immediate cause of death: Carcinoma Breast — Metastasis

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wallace A Barlow M. D.

Address 1101 St Paul St Date signed 12/7/46

G16301 | BALTIMORE CITY HEALTH DEPARTMENT | G16301

# CERTIFICATE OF DEATH 93D

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Dukeland & Ragnor Ave.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 Poplar Grove St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME GARRETT F. DE VED

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

(b) Name of husband or wife: Lula V. DeVed
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 20 1878

8. AGE: Years 68 | Months 2 | Days 17 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Mfr
11. Industry or business Iron + Metals

12. Name George L. DeVed
13. Birthplace New York.
14. Maiden Name Louise Schmidt
15. Birthplace New York.

16 (a) Informant Lula V. DeVed
(b) Address 1106 Poplar Grove St

17 (a) Burial (b) Date thereof Dec 10 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director's Harry H. Arnscock
(b) Address 4204 Ridgewood Ave

19 (a) DEC 9 1946 Registrar
(b) Date received

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7, 1946 at 3:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2, 1946 to Dec 7, 1946, and that I last saw him alive on Dec 7 1946.

Immediate cause of death: Respiratory Failure — Duration:
Due to CEREBRO-VASCULAR ACCIDENT
Due to HYPERTENSIVE ARTERIO SCLEROTIC VASCULAR DISEASE
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Gutmitzky M. D.
Address 3206 Lochdale Rd Date signed 12/5/46

X

G46302 Vola ✓ G46302

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1714 N. Carey St
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5-0 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 N. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vola M. Stanley
(b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex Fem.
5. Color or race Col.
6 (a) Single, married, widowed, or divorced. M.
(b) Name of husband or wife William
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 4-27-92
8. AGE: Years 54 Months 7 Days 9 If less than one day hr. min.
9. Birthplace T. B. Maryland (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business
12. Name James S. Martin
13. Birthplace Charlestown, S.C.
14. Maiden Name Rose Johnson
15. Birthplace S.C.
16 (a) Informant William Stanley
(b) Address 1714 N. Carey St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 9, 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore, Md.
18 (a) Funeral director Mrs. George N. Holland
(b) Address 1631 Druid Hill Ave.
19 (a) 12-9-1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-6-1946, at 1.00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 12, 1946, to Dec. 6, 1946, and that I last saw h.. alive on 12-6-1946

Immediate cause of death Cerebral Hemorrhage — Duration 1 Day

Due to Hypertensive Heart 5 mos.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Gage
Address 1816 N. Monroe St. Date signed 12-9-46

VS 150

X

G46303 BC# G46303

BALTIMORE CITY HEALTH DEPARTMENT ✓ G46303

Registered No.

962642

# CERTIFICATE OF DEATH 107

**PLACE OF DEATH:**

1. Baltimore City, Maryland
1. Street address 421 Druid Hill Ave.
1. Hospital or institution:

1. Length of stay in hospital or inst. (yrs., mos., or days) 11
1. Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

2 (d) Street No. 421 - Druid Hill Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME John C. Haley

(b) If veteran, name war

3 (c) Social Security Account No.

| Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| ale | colored | |

(b) Name of husband or wife

6 (c) If alive, give age years

Birth date of deceased (mo., day, yr.) Nov. 16, 1946

| AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 21 wo | hr. min. |

Birthplace Baltimore, Maryland
(Town, county, and state)

Usual Occupation
Industry or business Baby.

12. Name George Haley

13. Birthplace North Carolina

14. Maiden Name Geneva Jacobs

15. Birthplace North Carolina

(a) Informant Geneva Haley

(b) Address 421 Druid Hill Ave.

(a) Burial (b) Date thereof Dec. 9, 1946.
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery Mt. Calvary

Location Cedar Hill, Md.

(a) Funeral director A. Halstead

(b) Address 918 Druid Hill Ave.

DEC 9 - 1946 (a) (b)
(Date rec'd by reg.) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 6, 1946, at 10.40 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions Lobar Pulmonary Infection

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury.

23. Signature Howard J. Madeira M.D.
Medical Examiner.

Date signed 12-7-46

VS 151

X

G46304 G46304

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

131B Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 619 N. Paca Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 619 N. Paca Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country no.

**3 (a) FULL NAME** Minnie Click

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mc Coy
6 (c) If alive, give age: 47 years
7. Birth date of deceased (mo., day, yr.): March 15, 1900
8. AGE: Years: 46 Months: 8 Days: 21 If less than one day: hr. min.
9. Birthplace: South Carolina (Town, county, and State)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Bob Shell
13. Birthplace: South Carolina

MOTHER
14. Maiden Name: Janey ?
15. Birthplace: South Carolina

16 (a) Informant: Mc Coy Click
(b) Address: 619 N Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec. 10, 1946 (month) (day) (year)
(c) Cemetery: Mt. Calvary
Location: Cedar Hill Md.

18 (a) Funeral director: G. Halstead
(b) Address: 918 Druid Hill Ave.

19 Filed by registrar (b) Signature for Williams, Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: December 6, 1946 at 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1945, to Dec 6 1946 and that I last saw h[illegible] alive on Dec 6 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration: 14 mos

Due to: Arterio sclerosis generalized

Due to:

Other Conditions: Paralysis of muscles of swallowing 1 wk
Hemiplegia 2 Chronic Nephritis
(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operations:

of autopsy: none

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Ralph J Young M.D.
Address 1729 E Monument St Date signed Dec 8, 1946

VS 150

G46305

505276

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 148A

G46305 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1740 E. Madison St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Sherry Vann.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Black | Married |

6 (b) Name of husband or wife Wilmer
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) 10-29-02

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 44 | 1 | 6 | hr. min. |

9. Birthplace N. C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Wm Thomas Woodley
13. Birthplace Va.

MOTHER 14. Maiden Name Alberta White
15. Birthplace N. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Dec. 9/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location A. A. County, Md.

18 (a) Funeral director Mrs. Lotty A. Edwards Dept
(b) Address 1629 N. Carlton St.

19 (a) [illegible] (b) [illegible] Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 5 1946 at 11.33 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 25 1946 to Dec. 5 1946, and that I last saw her alive on Dec. 5 1946.

Immediate cause of death Respiratory failure — Duration 1 hr

Due to Pneumonia — 1 week

Due to Carcinoma Cervix Uteri IV — 1 year

Other Conditions Arthritis Luer

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Carcinoma pelvic lymph nodes Hydronephrosis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Newton Long M.D.
Address The Johns Hopkins Hosp. Date signed 12/6/46 M.D.

VS 150

3976 G46306

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48B

Registered No. G46306

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 84 College Creek Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Fay Greene

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| — | — |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Black | — |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-23-31

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 15 | 5 | 15 | hr. min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Clemen Greene
13. Birthplace Md.

MOTHER
14. Maiden Name Helen Blackson
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-12-46 (month) (day) (year)
(c) Cemetery or crematory New Hill Cemetery
Location West St. Ext. Annapolis Md.

18 (a) Funeral director Mrs Charles E. Hicks
(b) Address 45 northwest St. Annapolis Md.

19 (e) [illegible] for Williams Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8 1946 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20 1946 to Dec 8 1946 and that I last saw her alive on Dec 8 1946

| Immediate cause of death | Duration |
|---|---|
| Chronic epithelioma with metastasis | 4 mos |
| Due to Brain, lungs liver. | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: confirms

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. C. Sheaver M. D.
Address Johns Hopkins Hosp. Date signed 11-8-46

VS 150

G46307

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G46307 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2549 Flora
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs

13

**2. USUAL RESIDENCE OF DECEASED:**
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2549 Flora (If rural give location)
(e) Citizen of foreign country? Unk (Yes or No)
If yes, name country

3 (a) FULL NAME Alice McAbee

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Clayton McAbee 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 7-1888

8. AGE: Years 58 | Months 2 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore md (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Janet Woodland
13. Birthplace md

MOTHER
14. Maiden Name Anna Lee
15. Birthplace Virginia

16 (a) Informant Clayton McAbee
(b) Address 2549 Flora St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-10-46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Cem.
Location Catonsville Md.

18 (a) Funeral director Geo. T. A. Hyborn
(b) Address 1738 Druid Hill Ave

19 (a) (Date received by registrar) DEC 9 1946 (Registrar) M.H. Huntington Hall

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 6 1946 at 8:15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1946, to Dec 6 1946, and that I last saw h.. alive on Dec 5 1946

Immediate cause of death Cerebral Hemorrhage — Duration 17 hrs
Due to Chr. myocarditis — 1943
Due to
Other Conditions Diabetes — 1943

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James Jordan M. D.
Address 1663 W Mosher St. Date signed 12/9/46

93 D.

G46208

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 170c

G46208 Registered No.

**PLACE OF DEATH:**
) Baltimore City, Maryland
) Street address
) Hospital or institution: St. Agnes Hospital
) Length of stay in hospital or inst. (yrs., mos., or days) 23 hrs.
) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town ~~Baltimore~~ Catonsville 28
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~[illegible]~~ e. Catonsville 28
2216 Pleasant View Ave
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME: John J. Rest

(b) If veteran, name war: World I

3 (c) Social Security Account No. 318-14-1911

Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single.

(b) Name of husband or wife

6 (c) If alive, give age years

Birth date of deceased (mo., day, yr.) Dec. 18, 1886

| AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 11 | 18 | hr. min. |

Birthplace: Mary Land (Town, county, and state)

Usual Occupation: Ship Worker

Industry or business

12. Name: John A Rest

13. Birthplace: Germany

14. Maiden Name: Mary Hartman

15. Birthplace: Germany.

(a) Informant: Mrs. Margaret Bond

(b) Address: 2216 Pleasant View ave Catonsville

(a) Burial (Burial, cremation, or removal) (b) Date thereof 12-10-46 (month) (day) (year)

(c) Cemetery or crematory: Baltimore National

Location: Baltimore Md.

(a) Funeral director: H. C. Higinbotham

(b) Address: Ellicott City Md.

(c) DEC 9 - 1946 (Date rec'd by registrar) (d) Huntington Williams Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 6, 1946, 6.05 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Compound Comminuted fracture leg bones

Fracture 10th thoracic vertebra

Due to dislocation, 2nd to 3rd cervical vertebra

Other Conditions: Bronchopneumonia

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 28-4

(a) Date of injury 12-5-46 7.15 p. M.

(b) Where did injury occur? Frederick Ave. at Woodington Ave.

(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No

(d) Means of injury: Pedestrian-struck by auto

23. Signature: Howard J. Mc[illegible] M.D. Medical Examiner.

Date signed 12-7-46

VS 151

G16309 G16309

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1946

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mt. Wash. Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2929 Pulaski Highway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME: Minnie M. Fischer (Fisher)
(b) If veteran, name war: 1st World War
(c) Social Security Account No. None
4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
(b) Name of husband or wife: Mishuie Fischer
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 17 - 1894
8. AGE: Years 52 | Months 2 | Days 20 | If less than one day hr. min.
9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual Occupation: Water Dept.
11. Industry or business: Balto. City
12. Name: Geo. F. Fischer
13. Birthplace: Balto.
14. Maiden Name: Lucilla Myrick
15. Birthplace: Balto.
16. (a) Informant: Mrs. Minnie Fischer
(b) Address: 2929 Pulaski Hwy.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 11 46 (month) (day) (year)
(c) Cemetery or crematory: Balto. National
Location: Baltimore Md.
18. (a) Funeral director: Philip Herwig Sons
(b) Address: 2024 Orleans St.
19. DEC 9 - 1946 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7, 1946 at 8:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 7, 1946 to Dec. 7, 1946 and that I last saw him alive on Dec. 7, 1946

| Immediate cause of death | Duration |
|---|---|
| Cerebro - vascular accident | |
| Due to Hypertensive cardio-vascular heart disease | |
| Due to | |
| Other Conditions Uremia | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry T. Linger M.D.
M. D.
Address Balt. Baltimore General Hospital Date signed 12/7/46

VS 150

For Dr. Wm. S. Hayford by Howard J. Madden, M.D.

G46310 — AB-98863

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13 B

G46310 — Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10mos-10days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3742 Mt. Pleasant St. (Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Leo Senn

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 22- 1880
8. AGE: Years 66 | Months 10 | Days 16 | If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Labor.
11. Industry or business

FATHER
12. Name Lewis Senn
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Lenz
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 11 46 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Donnell St.

18 (a) Funeral director J. Walter Mayo
(b) Address 619 N. Bouldin St.

19 (a) Dec 9 1946 Date received by registrar Huntington Williams M.D.

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** December 8 1946, at 7.15 AM

**21.** I certify that death occurred on the date above stated; that I attended deceased from 1-28 1946 to 12-8 1946 and that I last saw him alive on 12-8- 1946

Immediate cause of death: Resp. Failure (a)
Due to: Pulmonary Tuberculosis
Due to:
Other Conditions: Osteomyelitis L Femur
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23.** Signature Wm L Scarborough M.D.
Address Balt City Hosp Date signed 12-8-46

G46311 G46311

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131A

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1711 E. Preston St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 E. Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Katie Norris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Jeffie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1906

8. AGE: Years 40. Months 4 Days 24 If less than one day hr. min.

9. Birthplace Alabama (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Jennings
13. Birthplace Alabama

MOTHER
14. Maiden Name Ella Strong
15. Birthplace Alabama

16 (a) Informant Jeffie Norris
(b) Address 1711 E. Preston St.

17 (a) Removal (b) Date thereof Dec 9/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Camp Hill Alabama

18 (a) Funeral director Wm. Colt A. Elliott Sons
(b) Address 1129 N. Eutaw St

19 (a) (Date rec'd by registrar) (b) Interment Arlington Hillsboro Ala

VS FEB 9 - 1946

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec. 6 1946, at 5.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/27 1946 to 12/6 1946 and that I last saw h[illegible] alive on 12/3 1946

Immediate cause of death: Hypertensive cardio-renal disease (cardiac failure) — Duration: 3 yrs 7

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature X Raynor Brown M.D.

Address 1 S W E. Madison St. Date signed 12/9/46

G46312

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 138

G46312 Registered No.

**PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 603 S. Hanover Street.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 603 S. Hanover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME JOSEPH A. DRASFIELD

(b) If veteran, name war

3 (c) Social Security Account No.

Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

(b) Name of husband or wife

6 (c) If alive, give age years

Birth date of deceased (mo., day, yr.) 1872

AGE: Years 74 Months Days If less than one day ____hr. ____min.

Birthplace Unknown (Town, county, and state)

Usual Occupation Unknown

Industry or business

12. Name Unknown

13. Birthplace Unknown

14. Maiden Name Unknown

15. Birthplace Unknown

(a) Informant None

(b) Address

(a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/46 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill Cem.

Location Relay Ft. Holloway

(a) Funeral director John J. Conway & Son

(b) Address 901 Hollins St.

(a) DEC 9 - 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 4, 1946, at 12:20 P.M.

21. I certify that I took charge of the remains described above, held an partial autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 12-4-46

VS 181

G16313

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 121

G16313 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1630 Madison St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Walter Taylor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Black | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 3 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | | | hr. min. |

9. Birthplace N. Ca. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Daniel Taylor
13. Birthplace N.C

MOTHER
14. Maiden Name Margaret Lotton
15. Birthplace N.C

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk
Location
18 (a) Funeral director Joseph B. Lozier
(b) Address 1303 N. Carrollton Ave
19 DEC 9 - 1946 (Date rec'd by registrar) Huntington Registrar

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH Dec. 7 1946 at 4.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-6 1946 to Dec-7 1946 and that I last saw him alive on Dec-7 1946.

| Immediate cause of death | Duration |
|---|---|
| Generalized Peritonitis | 1 wk |
| Due to Ruptured Gangrenous Appendix | 1 wk |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 12-7-46
Major findings of operation: Peritonitis
of autopsy: SAME

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard C. May M. D.
Address Johns Hopkins Hosp. Date signed 12-7-46

VS 130

D46317. BALTIMORE CITY HEALTH DEPARTMENT D46314
Registered No.

# CERTIFICATE OF DEATH 94A

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 907 W. 40th St Dist.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 907 W. 40th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME Harry Bottle

(b) If veteran, name war —

3 (c) Social Security Account No. 216-09-0493

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

(b) Name of husband or wife Etta M. Bottle

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Oct 7, 1900

| AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | 2 | 0 | hr. min. |

8. Birthplace Maryland
(Town, county, and state)

9. Usual Occupation Shipfitters
10. Industry or business Bolding Park Co.

12. Name John W. Bottle
13. Birthplace Maryland

14. Maiden Name Mary G. Stauffer
15. Birthplace Maryland

16. (a) Informant Etta M Bottle
(b) Address 907 W 40th St

17. (a) Burial (b) Date thereof Dec 10 /46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Poplar
Location Balto Co, Md

18. (a) Funeral director Chenoweth & Donovan
(b) Address 3615-17 Christmas Ave.

19. (a) Date received by registrar DEC 9 1946 (b) Huntington Williams, M.D.
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/7 19 46 at 10 40 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 12/7/46

G46315

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93E

G46315 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3520 Alton Road
(c) Hospital or institution: Alton Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3318 Spalding Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country Spain Italy

3 (a) FULL NAME M. Geneva Bowen

3 (b) If veteran, name war —

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife George W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 0 | 15 | hr. min. |

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business "

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Grace E. Holmes
(b) Address 3318 Spalding Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-10-46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Maryland

18 (a) Funeral director Lazine Byers
(b) Address 5005 Pat. Hgwy Balto

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 9 - 1946

Huntington Pharmacy

**MEDICAL CERTIFICATION**

20. DATE OF DEATH ~~Dec~~ Dec 7, 1946, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 5 1946, to Dec 7 1946, and that I last saw h.er alive on 12/7 1946.

Immediate cause of death: Myocarditis

Duration: 4 days

Due to: arterio-sclerosis — Duration: 2 mo.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Walter Dukat M. D.
Address 2220 Harrison Blvd. Date signed 12/9/46

G46316

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 106 B

G46316 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1653 N. Milton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1653 N. Milton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha R. Hanf

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Karl F. Hanf

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/9/60

8. AGE: Years 86 | Months 9 | Days 0 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name — — Hanf.
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mr. Wm Bamber
(b) Address 1653 N. Milton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 12 46 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto. Md

18 (a) Funeral director Franklin Funeral Home
(b) Address 7401 Belair Rd.

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150 DEC 9 - 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9th 1946, at 10:53 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 1946, to 12/9 1946, and that I last saw h e alive on 12/9 1946.

Immediate cause of death Old age.
Due to Chronic Bronchitis
Due to
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: —
of autopsy: none

Duration
Immediate cause: Unknown
Due to:
Due to:
Other Conditions:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? none While at work? no
(Specify type of place)
(e) Means of injury —

23. Signature A. C. Hearn M.D.
Address 7401 Belair Rd Date signed 12/9/46

G46317 HEALTH DEPARTMENT—CITY OF BALTIMORE G46317

87D

# CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 5702 Birchwood Rd 6 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 34 yrs. mos. 7 ds. How long in U. S. If of foreign birth? 73 yrs. mos. ds.

2. FULL NAME Conrad Karl Kissel

If U.S. Veteran specify WAR

(a) Residence: No. 5702 Birchwood Rd St., 27 Ward.

(Usual place of abode) (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| SEX | 4. Color or Race | 5. Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| M | White | Married |

6. If married, widowed, or divorced, HUSBAND of (or) WIFE of Magdalena Fritzel Kissel

DATE OF BIRTH (Month, day, year) Nov. 30, 1873

| AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 73 | 0 | 7 | |

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Lithographer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Lithographing

10. Date deceased last worked at this occupation (month and year) July 1, 1943

11. Total time (years) spent in this occupation 56

12. BIRTHPLACE (city or town) (State or country) New York City U.S.A.

13. NAME Conrad Kissel

14. BIRTHPLACE (city or town) (State or country) Germany

15. MAIDEN NAME Anna Vail

16. BIRTHPLACE (city or town) (State or country) New York City N.Y.

INFORMANT Magdalena Kissel

(Address) 5702 Birchwood Ave

BURIAL, CREMATION OR REMOVAL

Place Parkwood Date 12/11- 1946

UNDERTAKER Leonard D. Kyle

(Address) 5305 Harford Rd.

FILED 19

Registrar.

9 - 1946 Huntington Williams, M.D.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) DEC 8, 1946

22. I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1946 to DEC 8, 1946

I last saw him alive on DEC 8, 1946. Death is said to have occurred on the date stated above, at 12:45 p.m.

The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| HYPERTENSION | 7 Yrs |
| ARTERIOSCLEROSIS | |
| CEREBRAL SCLEROSIS | 8 Days |
| PULMONARY EDEMA | 1 Day |

Other contributory causes of importance:

Was an operation performed? NO Date of

For what disease or injury?

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? NO If so, specify

(Signed) Walter E. Hoffman, M. D.

(Address) 4331 Harford Rd.

G46318

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94A

G46318 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6822 Harford Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Mrs. Mary E. Nelson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race W | 6 (a) Single, married, widowed or divorced. ~~Married~~ Married

6 (b) Name of husband or wife John Nelson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/18/87

8. AGE: Years 59 | Months 0 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation at home

11. Industry or Business

FATHER 12. Name John Traffley

13. Birthplace -

MOTHER 14. Maiden Name Margaret -

15. Birthplace

16 (a) Informant Mrs. Shepidge Hedrick

(b) Address 6822 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/46 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Balto

18 (a) Funeral director Leonard J. Rusk

(b) Address 5305 Harford Rd

19 (a) (Date rec'd by registrar) Huntington Williams M.D. Registrar

9-9-150 1946

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 12/6/46 19, at 10:10 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from 11/16 1946 to 12/6 1946 and that I last saw her alive on 12/6 1946.

Immediate cause of death — Duration

Due to Anterior Coronary A. Occlusion

Due to Coronary Sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John Brietz M.D.

Address 1 Hopkins Place Date signed 12/6/46

43-1

G46319

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

G46319
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Dukeland + Raynor
(c) Hospital or institution:
West Balto Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State ? (b) County
(c) City or town ?
(If outside city or town limits, write RURAL and give town)
(d) Street No. ?
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca J McPhillimy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race White

6 (a) Single, married, (widowed) or divorced.

6 (b) Name of husband or wife Wm. McPhillimy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1873

8. AGE: Years 73 | Months 7 | Days 2 | If less than one day hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation -

11. Industry or business -

FATHER
12. Name James Fulton
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Campbell
15. Birthplace Ireland

16 (a) Informant Mr. Ed. J. McPhillimy
(b) Address 1512 McKinley St., Phila., Pa.

17 (a) Removal (b) Date thereof 12/9/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Maria
Location Philadelphia, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Huntington Williams, M.D. (b)
(Date filed by registrar) Registrar

12-9-1946
VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-8 1946, at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-2 1946 to 12-8 1946, and that I last saw he[r] alive on 12-8 1946

| Immediate cause of death | Duration |
|---|---|
| Gangrene of Right Leg | |
| Due to Arterial Embolism | |
| Due to Arteriosclerotic Heart Disease | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Berdiansky M. D.
Address WBGH Date signed 12/9/46

X

JL - 106 816320

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. 816320

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore Coty Hospitals 25-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2215 Sidney Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Bessie Reeside

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife William Martin Reeside
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 4 | 13 | hr. min. |

9. Birthplace York, Pa.
(Town, county, and state)
10. Usual Occupation H. Wife
11. Industry or business

MOTHER / FATHER
12. Name William S. Strickler
13. Birthplace Md.
14. Maiden Name Margretta Jones
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12/12/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location York, Pa.

18 (a) Funeral director John A. Wagner
(b) Address 3010 E. Baltimore St.

19 (a) (b)
(Date rec'd by registrar) Registrar

DEC 10 1946

VS 150

Huntington Williams

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9 1946, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20 1946, to Dec. 9 1946, and that I last saw h. alive on Dec. 9 1946

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure | 4 |
| Due to HCVD & cardiac decompensation. | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Doyle Walker M. D.
Address UCH Date signed 12/12/46

X

G46321

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G46321

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 807 McKim st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 2

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 807 McKim st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Nellie M. Dawson

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| W | NONE |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Thomas V. Dawson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15th 1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 4 | 23 | hr. min. |

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name William Hahn
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Samuel E. Brown
(b) Address 3132 Presstman St.

17 (a) Burial (b) Date thereof 12/11/46
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) (Date received by registrar) (b) [illegible] for Wm. Registrar

DEC 10 1946

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8th 1946, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/8/46 19 46, to 12/8 19 46, and that I last saw h alive on 12/8 19 46.

| Immediate cause of death | Duration |
|---|---|
| Arteriosclerotic Cardio-Vascular Disease | |
| Due to | |
| Due to | |
| Other Conditions Senility | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Delmar Laughlin M. D.
Address 400 N. Payson St. Date signed 12/9/46

X

G46322

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 170 C

G46322 Registered No.

**PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital 27-12 Doa.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6115 Bellona avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

(a) FULL NAME Joseph A. Verrier

(b) If veteran, name war | (c) Social Security Account No.

Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

(b) Name of husband or wife: Lucinda Verrier

6 (c) If alive, give age years

Birth date of deceased (mo., day, yr.) Dec 22nd 1866

| AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 11 | 17 | hr. min. |

Birthplace: Indiana (Town, county, and state)

Usual Occupation: Cabinet Maker

Industry or business

12. Name: Joseph Verrier

13. Birthplace: Canada

14. Maiden Name: ? Seville

15. Birthplace: Canada

(a) Informant: Alma Verrier

(b) Address: 6115 Bellona Ave

(a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/46 (month) (day) (year)

(c) Cemetery or crematory: Cathedral

Location: Balto. Md.

(a) Funeral director: William Cook Inc.

(b) Address: 1217 St. Paul St. Huntington Williams, Mgr.

(a) (Date rec'd by registrar) DEC 1 (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 7, 1946, at 12 55 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Impacted fracture of the first and second cervical vertebrae,

Due to: Epi and Subdural hemorrhage of brain (base)

Other Conditions: Fractured ribs, Brush burns.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 12-7-46 at 12 30 A. M. 27/4

(b) Where did injury occur? Belair Road & Parkwood Avenue

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.

(d) Means of injury: Ped. Struck by auto.

23. Signature: Howard J. Mesmer M.D. Medical Examiner.

Date signed 12/9/46

VS 151

X

G46323

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1928

Registered No. G46323

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home & Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 48 days
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 516 W (25) th St. 516 W 27th St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) FULL NAME Mr. Milton Jamhauser.
(b) If veteran, name war —
(c) Social Security Account No. 219-16-7692
4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced. Widowed
(b) Name of husband or wife [illegible] (Maria K.)
(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 9 1874
8. AGE: Years 71 72 Months 10 Days 29 If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Retired Cotton Broker

MOTHER'S MAIDEN NAME
12. Name Lederick Grandhauser
13. Birthplace Md.
14. Maiden Name Elizabeth Haney
15. Birthplace Md.

16. (a) Informant Mrs Grandhauser
(b) Address 2126 Mt. Ave. Apt #309
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/46 (month) (day) (year)
(c) Cemetery Westerns
Location Balto. Md.
18. (a) Funeral director Williams Gott Inc.
(b) Address 317 St. Paul St.
19. DEC 10 1946 (Date rec'd by registrar) (b) Huntington Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8 1946, at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 21 1946, to Dec 8 1946, and that I last saw him alive on Dec 8 1946.

Immediate cause of death Suppuration of lungs — Duration 10 days
(b) due to Lobular Pneumonia — 10 yrs.
Due to Sclerosis aortic valve. — 10 yrs.
Cardiac hypertrophy. — 2 mos.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: autopsy = pneumonia, suppuration, aortic sclerosis, cardiac hypertrophy
of autopsy: Heart disease.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature David Bachmeyer M. D.
Address Church Home & Hosp. Date signed Dec 9, 46

VS 190

G46324

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G46324 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 501 N. Pulaski Street
(c) Hospital or institution: Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 St Paul Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian M. Lehnhoff (Lillian M. Lehnhoff)
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Wm Lehnhoff
6 (c) If alive, give age
7. Birth date of deceased (mo., day, yr.) Dec 29 1882
8. AGE: Years 63 | Months 11 | Days 10 | If less than one day ___ hr. ___ min.
9. Birthplace St Marys County (town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name John Gable Perry
13. Birthplace St marys county

MOTHER
14. Maiden Name Chudeona King
15. Birthplace St Marys County

16 (a) Informant Mrs. Blanche Callaghan
(b) Address 501 N. Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director Wm. Cook Inc
(b) Address 1217 St Paul Street

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 1946, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/8/46 19 to 12/9/46 19, and that I last saw h[illegible] alive on 12/9 1946.

| Immediate cause of death | Duration |
|---|---|
| Acute cardiac dilatation | 3 hrs. |
| Due to Chronic myocarditis | |
| Due to hypertension | 4 yrs |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. Palas M. D.
Address 4 N. Fulton Ave. Date signed

VS 150

G46325
No. 106402

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH ✓ 48a

G46325
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 E. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Martha Koetzner

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NINE

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: ~~M~~ Widow

6 (b) Name of husband or wife: Michael V. Koetzner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June ? 1861 ?

8. AGE: Years 85 ? Months 6 June Days ? If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Joseph King
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Brown
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Extended

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION** P.M

20. DATE OF DEATH December 7th 1946, at 4:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26th 1946 to Dec 7th 1946 and that I last saw h~~im~~er alive on Dec 7th 1946.

| | Duration |
|---|---|
| Immediate cause of death: Massive hemorrhage, uncontrollable. | |
| Due to: Carcinoma of cervix with metastasis | |
| Due to: | |
| Other Conditions: Arteriosclerotic cardiovascular disease | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. H. Gibbs M. D.
Address Baltimore City Hosp. Date signed 12/7/46

VS 150

G46326

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 46F

G46326 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Del (b) County
(c) City or town Wyoming (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary N. Fifer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Charles F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 10 1873

8. AGE: Years 72 Months 11 Days 25 If less than one day hr. min.

9. Birthplace Port Republic Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Peter A Shroyer

13. Birthplace Port Republic Md

MOTHER 14. Maiden Name Magdalina Statwole

15. Birthplace Md

16 (a) Informant Mrs J Fifer

(b) Address 810 Copley Rd

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/10/46 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Port Republic Md

18 (a) Funeral director Mathews Funeral Home

(b) Address 1210 E Pratt St

19 (a) Date received DEC 10 1946 (b) Registrar Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 10 1946; at 12 25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24 1946, to Dec. 10 1946, and that I last saw him alive on Dec. 10 1946

Immediate cause of death Uremia;

Due to Kidney damage

Due to Generalized arteriosclerosis

Other Conditions Carcinoma of Cervix hist. dx.
(Include pregnancy within 3 months of death)

Date of operation Dec 2, 1946

Major findings of operation: Large mass encircling ureters & bladder

of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. E. McCurdy M. D.

Address University Hosp. Date signed 12/10/46

X

G46327

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G46327

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3300 Ramona Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3300 Ramona (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Kaetana John Neuberger Sr

3 (b) If veteran, name war

(c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Elizabeth Neuberger
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Nov 6 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 1 | - | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business

FATHER
12. Name Martin Neuberger
13. Birthplace Baltimore

MOTHER
14. Maiden Name Katherine Nuetzelberger
15. Birthplace Baltimore

16 (a) Informant Miss Ruth Neuberger
(b) Address 3300 Ramona Ave.

17 (a) Burial (b) Date thereof Dec 10/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Co Md

18 (a) Funeral director Wilhelm Funeral Home
(b) Address 2008 Orleans St

19 (a) (b) Registrar
(Date rec'd by registrar)

DEC 10 1946
Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 6th 1946, at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2 1946 to Dec. 6 1946, and that I last saw h[illegible] alive on Dec. 6 1946.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of Left Lung | 1 mo. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Carcinoma of Lung

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: Dr. L. W. Bosley
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry B. Kelly M. D.
Address 2504 St Paul St Date signed 12/8/46

X

G46328

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46E

Registered No. G46328

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1714 N. Bradford
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 + 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 N. Bradford St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Louise Schubert

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Wm Schubert
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) June 1 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 6 | 7 | ____hr. ____min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Columbus Oliver
13. Birthplace Baltimore

MOTHER
14. Maiden Name Wilhelmina Jorenhaus
15. Birthplace Baltimore

16 (a) Informant Wm Schubert
(b) Address 1714 N Bradford St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 11 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2105 Gleans St

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8th 1946, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 19 46 to [illegible] 19 46, and that I last saw h[illegible] alive on [illegible] 19 46

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | Days |
| Due to | 14 |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature [illegible] M. D.
Address [illegible] Date signed [illegible]

VS Form DEC 10 1946

Huntington Williams, M.D.

G16329

505329.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1929

G16329

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 - 4
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 W. Bullough St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Harry L. Dudley

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Black | Married |

6 (b) Name of husband or wife Mabel.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-14-11

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 35 | 4 | 22 | hr. min. |

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name George Dudley
13. Birthplace N. C.

MOTHER
14. Maiden Name Hettie Moore
15. Birthplace N. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 12, 1946 (month) (day) (year)
(c) Cemetery or crematory
Location Wilmington N. C.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by Reg.) (b) Registrar

Dec 10 1946 Huntington Mills

VS 450

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 6 1946, at 12 m. Midnight or P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1946 to Dec. 6 1946, and that I last saw him alive on Dec. 6 1946

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Embolism & multiple pulmonary infarcts | 2-3 Mo's |
| Due to Thrombophlebitis of Lt. Leg. | 10 Mo's |
| Due to 9503 | |
| Other Conditions Cor. pulmonale, Decompensated insufficiency (Relative) | |

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene Hughes M.D.
Address Johns Hopkins Hosp. Date signed Dec. 7, 1946

X

BC# G46330 G58637

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G46330

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 10 D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 927- E. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME: Pauline Little

(b) If veteran, name war

3 (c) Social Security Account No.

Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

(b) Name of husband or wife

6 (c) If alive, give age years

Birth date of deceased (mo., day, yr.) Sept 26-1946

| AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 2 | 12 | hr. min. |

Birthplace Baltimore
(Town, county, and state)

Usual Occupation None

Industry or business

12. Name Preston Little

13. Birthplace N.C

14. Maiden Name Classie Alston

15. Birthplace N.C

(a) Informant Classie Alston

(b) Address 925 E Madison St

(a) Burial (b) Date thereof 12-8-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A. A. Co.

(a) Funeral director Rayner Sanders

(b) Address 1412 E. Preston St

(a) (b) Huntington Williams, M.D.
Registrar

DEC 10 1946

VS 181

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8, 1946, at 5.10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Extensive first-, second-, and third- degree burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-8-46 at 4.30 P.M. 10/2
(b) Where did injury occur? 927- E. Madison St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Explosion oil stove

23. Signature George G. Merrill M.D.
Medical Examiner.

Date signed 12-9-46

X

BALTIMORE CITY HEALTH DEPARTMENT

[redacted] G46331 CERTIFICATE OF DEATH 167 G46[redacted] Registered No. [redacted]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted]
(c) Hospital or institution: Johns Hopkins Hosp. 5th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 HRS.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Canal Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME Dave Frazier

(b) If veteran, name war —

3 (c) Social Security Account No. 237-14-2744

| Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Married |

(b) Name of husband ~~or wife~~ Easter Frazier
6 (c) If alive, give age years

Birth date of deceased (mo., day, yr.) 2/9/10

| AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 37 | 9 | 25 | hr. min. |

Birthplace S C
(Town, county, and state)

Usual Occupation Balto City Laborer
Industry or business

12. Name Ben. Frazier
13. Birthplace S C
14. Maiden Name Annie Tilley
15. Birthplace S C

(a) Informant Easter Frazier
(b) Address 1208 Canal Ct

(a) Burial (b) Date thereof Dec 10-1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cemetery
Location A. A. Co. Md.

(a) Funeral director Robert E Williams
(b) Address 1515 McElderry St

(a) (b) Huntington Williams
(Date rec'd by registrar) DEC 10 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-4-1946, at 10:25 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Stab-wound into right chest cavity and right lung, with massive hemorrhage into right chest cavity.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9:30 P.M. at 12/4/46 P.M.
(b) Where did injury occur? 1208 Canal Ct
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Stabbed with Sharp Instr.

23. Signature George G. Merrill, M.D.
per Howard J. Mueller M.D.
Medical Examiner.
Date signed 12-4-46

X

G46332 — BALTIMORE CITY HEALTH DEPARTMENT — G46332

Th. 106121 — CERTIFICATE OF DEATH — 132 — Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 Argyle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Ruth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mamie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 2nd 1898

8. AGE: Years 48 | Months 4 | Days 5 | If less than one day hr. min.

9. Birthplace S. C
(Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business

FATHER
12. Name BENJAMIN RUTH
13. Birthplace ? E.A

MOTHER
14. Maiden Name Elizabeth FAIR
15. Birthplace xx S. C

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-12-46 (month) (day) (year)

(c) Cemetery or crematory MT. CALVARY - CEM
Location A. E. COUNTY - MD.

18 (a) Funeral director Williams & Jackson
(b) Address 916 Pennsylvania ave

19 (a) (Date rec'd by registrar) (b) Registrar

vs DEC 10 1946 Huntington Williams, MD

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 7th 19 46 at 7.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29th 19 46 to Dec 7th 19 46 and that I last saw h. im alive on Dec. 7th 19 46.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Tuberculosis, Far Advanced | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation autopsy: Same plus thrombosis of right pulmonary

of autopsy ahtely, Ltd.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G Bird M. D.

Address Balto City Hosp. Date signed 12-9-46

X

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46333 / 131a

Registered No. G46333

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 207 E. Hamburg St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24-3
(e) Length of stay in Baltimore (yrs., mos., or days) about 30 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 E. Hamburg St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Germany.

**3 (a) FULL NAME** Helma Stieler

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Henry Stieler
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 3 | 6 | hr. min. |

9. Birthplace Rheinland, Germany (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Wilhelm Wolf
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Appel
15. Birthplace Germany

16 (a) Informant Mrs. Margaret Kriewald (Daughter)
(b) Address 1051 S. Charles St. Balto. Md.

17 (a) Burial (burial, cremation, or removal) (b) Date thereof Dec. 11, 1946 (month) (day) (year)
(c) Cemetery or crematory Oakdawn Cemetery
Location Balto. Co., Md.

18 (a) Funeral director A. H. Howard Evans
(b) Address 4005 Charles St., Balto 39

19 (a) (Date rec'd by registrar) (b) (Signature)

VS DEC 10 1946 Huntington

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 1946 at 9:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6 1946 to Dec 9 1946 and that I last saw him alive on Dec 9 1946.

Immediate cause of death: (a) Edema of Lungs
Conditions contributing but not related to cause given in (a): Cardiac Insufficiency
Duration: 2 days

Due to:
Due to:
Other Conditions: Chronic Nephritis
Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. L. Luitzenburg M.D.
Address 108 E. Northern Date signed Dec 10 1946

X

G46334 Norton

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 51B

G46334 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: Sinai Hospital 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto City
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 Byrd Pl
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** George M. Norton

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | No |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Divorced |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 9 | 23 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Turntable operator
11. Industry or business B&O

FATHER
12. Name Nathaniel Norton
13. Birthplace Dont know

MOTHER
14. Maiden Name Annie Baumgardner
15. Birthplace Dont know

16 (a) Informant Mrs Spriggs
(b) Address 1518 Byrd Pl

17 (a) Burial (b) Date thereof Dec 11 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto City

18 (a) Funeral director C. Howard Evans
(b) Address 1400 Lemmon St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 1 DEC 10 1946

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 8 Dec 1946 at 11 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11 Nov 1946 to 8 Dec 1946, and that I last saw him alive on 8 Dec 1946

| Immediate cause of death | Duration |
|---|---|
| Acute pulmonary edema | |
| Due to | |
| Due to | |
| Other Conditions Carcinoma of prostate (Include pregnancy within 3 months of death) | |

Date of operation 6 Dec 46
Major findings of operation: carcinoma of prostate with metastasis
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold M. Jordan M. D.
Address Sinai Hospital Date signed 9 Dec 46

G16335

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1216

G16335 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2828 Montebello Terr.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 2
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2828 Montebello Terr.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARGARET W. LAUGHLIN

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Wm. J. Laughlin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 24, 1856

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 90 | 3 | 14 | hr. min. |

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Frederick Wagner
13. Birthplace: Germany

MOTHER
14. Maiden Name: Christine Preis
15. Birthplace: Germany

16 (a) Informant: James F. Laughlin
(b) Address: 2828 Montebello Terr.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/46 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cem.
Location: Baltimore, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar: Huntington Williams, M.D.

DEC 10 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 8, 1946, at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1930 to Dec 8 1946 and that I last saw h alive on Dec 7 1946.

| Immediate cause of death | Duration |
|---|---|
| Cardiac vascular disease | 5 yrs. |
| Due to Chronic nephritis | 5 yrs. |
| Due to | |
| Other Conditions Senility | |

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Fitz J Thurgen M. D.
Address 2700 W Lord Balto Md Date signed Dec 9 1946

G46336

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1946

Registered No. G46336

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3118 Presbury Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 6
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3118 Presbury Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ALEXANDER M. RUTHERFORD

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 214-03-0631

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife: Maude E. Rutherford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 9 | 6 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Linotype Operator
11. Industry or business A. S. Abell Co.

FATHER
12. Name Wm. H. Rutherford
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Isabel Anderson
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Maude E. Small
(b) Address 3118 Presbury St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 7, 1946, at 1:45P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1942 to Dec 7 1946, and that I last saw him alive on Dec 7 1946

| Immediate cause of death | Duration |
|---|---|
| Coronary occlusion | 2 hrs |
| Due to Advanced arteriosclerosis | ? |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death ~~was due to external causes~~, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter D. Talbott M. D.
Address 2220 Harlem Date signed

V S 15 DEC 10 1946 Huntington Williams, M.D. Dec 9/46 X

G16337

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

Registered No. G16337

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3319 Moulla St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 + 11
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto - (If outside city or town limits, write RURAL and give town)
(d) Street No. 3319 Moulla St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

**3 (a) FULL NAME** Alta V. Eckes

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F. | W. | Married |

6 (b) Name of husband or wife Harry H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/13/84

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 4 | 25 | hr. min. |

9. Birthplace Baltimore - (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name George Harper
13. Birthplace Balto

MOTHER
14. Maiden Name Minnie ?
15. Birthplace Balto -

16 (a) Informant William Eckes (son)
(b) Address 1812 Kirkside Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/46 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Belair Rd.

18 (a) Funeral director Lilly & Zeller
(b) Address 402 S. Wolfe St.

19 (a) DEC 10 1946 (Date received by registrar) (b) Huntington Williams, M.D.

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-8-46 19 , at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2-45 19 , to 12-8-46 19 , and that I last saw h[illegible] alive on 12-8-46 19 .

| Immediate cause of death | Duration |
|---|---|
| Diabetes Insulitus | 12-45 |
| Arteriosclerosis C-V Disease | 11-2-45 |
| Due to Acute Coronary Thrombosis | 12-8-46 |
| Due to | |
| Other Conditions None | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Schumunek M. D.
Address 842 S. Ellwood Ave Date signed 12-10-46

G46338

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G16338 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2540 Edmondson ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lola Blizzard

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | W | Married |

6 (b) Name of husband or wife Vern Blizzard
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) April 10, (1883) 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 (63) | 7 8 | 29 | hr. min. |

9. Birthplace Ohio
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name (Morton) French
13. Birthplace Ohio

MOTHER
14. Maiden Name Phebe Nesbett
15. Birthplace Ohio

16 (a) Informant Robert Blizzard - Son
(b) Address 2540 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn (Baltimore) Maryland
Location (Baltimore) Maryland

18 (a) Funeral director Lilly & Zeiler
(b) Address 403 N Eutaw St

DEC 10 1946

19 (a) (Date rec'd by registrar) (b) Huntington, West Virginia

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Dec 9 1946, at 8:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1946 to Dec 9 1946, and that I last saw h-- alive on Dec 9 1946

| Immediate cause of death | Duration |
|---|---|
| Myocardial failure | |
| Due to Hypertension and Cardio-vascular disease | |
| Due to Generalized Arteriosclerosis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard S Linder M. D.
Address South Dutch Conshohocken Date signed 12-14-46

VS 150

6339 2400 E Eaton Pl

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 6316339

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1825 E. Pratt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1825 E. Pratt St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary L. Wagner

3 (b) If veteran, name war | (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F. | White | Widowed |

6 (b) Name of husband or wife Joseph.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6/1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 8 | 4 | hr. min. |

9. Birthplace Hazelton Penna.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Paul L. Agar.
13. Birthplace Penna.

MOTHER
14. Maiden Name Susan Schlenker
15. Birthplace Penna.

16 (a) Informant Magdelene Fendrick
(b) Address 825 E. Pratt St.

17 (a) Burial (b) Date thereof 12/14/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Joseph's
Location Hazelton Pa.

18 (a) Funeral director Selby & Zeiler Inc
(b) Address 403 N. Wolfe St

19 (a) DEC 10 1946 (b) Huntingdon Pa.
(Date rec'd by Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 10 - 1946, at 12/30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb - 1943, to Dec - 10 - 1946, and that I last saw h alive on Dec. 10 - 1946

Immediate cause of death Pulmonary Embolism — Duration: Indefinite

Due to Mitral stenosis & aortic insufficiency

Due to Rheumatic heart disease

Other Conditions Hypertension & chronic nephritis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Herman Seidel M. D.
Address 2404 E. Eaton Pl Date signed 12/10/46

V S 150

46340

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1469

Registered No. G46340

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3615 Second St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) Brooklyn
(d) Street No. 3615 2nd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Christina Stumpf

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | W |

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/22/1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 11 | 15 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Family
(b) Address 3615 Second St.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 12/10/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn, Md.

18 (a) Funeral director L. M. Cauley
(b) Address 130 E. Hoffman.

19 DEC 10 1946 (Date rec'd by registrar) (b) Huntington Williams, Md. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 7, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5 1946, to Dec 7 1946 and that I last saw her alive on Dec. 6, 1946.

Immediate cause of death Carcinoma of the pancreas — Duration 11 mos.
Due to
Due to
Other Conditions Hypertension Cardio vascular disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Harry Deitel M. D.
Address 1226 Hanover St Date signed 12/9/46

6341

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

G16341 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 531 Bloom St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 + 3
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 531 Bloom St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susie Conaway

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Chas. Conaway
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1888

8. AGE: Years 58 | Months 6 | Days 11 | If less than one day hr. min.

9. Birthplace Leesburg, Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Samuel Wheeler
13. Birthplace Va.

MOTHER 14. Maiden Name Jane —
15. Birthplace Va

16 (a) Informant Beulah Diggs
(b) Address 1908 13th St. N.W. Wash DC

17 (a) Burial (b) Date thereof 12 | 11 | 46
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. B. Kelsey
(b) Address 1303 Pennsylvania Ave

19 (a) DEC 10 1946 (b) Registrar Huntington Williams
(Date received by Registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12 | 7 | 1946, at 1830 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 3 | 1 | 1946 to 12 | 7 | 1946 and that I last saw h. alive on 12 | 5 | 1946

Immediate cause of death: Chronic Myocarditis — Duration 2yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 1 E W Fayette St Date signed 12/10/46

X

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CWK-91461

# CERTIFICATE OF DEATH 30c

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days): 1 - 11 - 2 26-12
(e) Length of stay in Baltimore (yrs., mos., or days): 20 Yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: Maryland (b) County:
(c) City or town: Hagerstown (If outside city or town limits, write RURAL and give town)
(d) Street No.: Not Given (If rural give location)
(e) Citizen of foreign country?: (Yes or No)
If yes, name country:

**3 (a) FULL NAME:** Carrie Smiley

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Separated |

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): December 3-1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 0 | 5 | hr. min. |

9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation:
11. Industry or business:

FATHER
12. Name: Deaton Malotte
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Mary Walsh or Welch
15. Birthplace: Maryland

16 (a) Informant: Records-Balto. City Hospitals
(b) Address: 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-46 (month) (day) (year)
(c) Cemetery or crematory: CATHEDRAL
Location:

18 (a) Funeral director: WIEDEFELD & SON
(b) Address: GREENMOUNT & 22ND

19 (a) DEC 10 1946 (b) (Date rec'd by Local Reg.) Huntington Willard, Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: December 8 1946, at 5:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from: Dec. 8 1945, to Dec. 8 1946, and that I last saw h.er alive on: Dec. 8 1946.

Immediate cause of death: Cerebro-vascular accident — Duration:
Due to: Arteriosclerotic cardio-vascular disease
Due to:
Other Conditions: Old fracture left tibia CNS Lues
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: Accident
(b) Date of occurrence: December 8, 1946 ? M
(c) Where did injury occur?: Baltimore (City or town) Md (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?: public - City Hosp. (specify type of place) While at work? no
(e) Means of injury: fell on floor, getting into wheelchair

23. Signature: H. L. Gibbs
Address: Baltimore City Hosp. Date signed: 12/9/46

Howard J. Masseria, M.D.

VS 150

16343

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G16343

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution:
University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~1637 E. Chase St.~~
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur M Parks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 11 1899

8. AGE: Years 47 | Months 3 | Days 27 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Sweeper & Cleaner

11. Industry or business

FATHER 12. Name Malachai Parks.

13. Birthplace Md.

MOTHER 14. Maiden Name Emma Livingston

15. Birthplace Md.

16 (a) Informant Arthur Parks

(b) Address none

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12-11-46 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Frederick Road

18 (a) Funeral director John C. Myers

(b) Address 2435 E. Oliver St

19 (a) DEC 10 1946 (Date received by Registrar)

Huntington Hillsville, Md

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-8 1946, at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-7-46 19 to 12-8 1946, and that I last saw him alive on 12-8 1946.

Immediate cause of death Overwhelming Toxicity — Duration

Due to Lobar Pneumonia Bilateral lower lobes —

Due to Alcoholism & Exposure

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. K. Briggs M. D.

Address Univ. Hosp Date signed 12/10/46

VS 150

X

46344 BC# G 63378

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

159

Registered No. G16344

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44ays
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 657 George Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Vivian Bradley

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | Col. | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 26-1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 4 | hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Bradley
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof 12. 9. 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave

18 (a) Funeral director
(b) Address

19 (a) DEC 11 1946 (b) Huntington Williams
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1946, at 6.15A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-26- 1946 to 11-30 1946, and that I last saw h er alive on 11-30- 1946

Immediate cause of death: Prematurity — Duration: life

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes M.D.
Address Balto City Hosp Date signed Dec 6 1946

VS 150

X

G46345

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

Registered No. G46345

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 711 Brinkwood Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Brinkwood Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ida Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband ~~wife~~ George W

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 26 1887

8. AGE: Years 58 | Months 11 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Matthew Ganser
13. Birthplace Germany

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Mr George W Hill
(b) Address 711 Brinkwood Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 12 '46 (month) (day) (year)

(c) Cemetery or crematory London Park
Location 3801 Edmondson Ave

18 (a) Funeral director Harry W Hafer
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

Dec 10 1946

Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946, to Dec 9 1946, and that I last saw her alive on Dec 8 1946

| | Duration |
|---|---|
| Immediate cause of death General Cardiovascular | 7 Mos |
| Due to Cardiovascular of heart. | 1943 |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation 3 days ago

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. P. Van Schaick M.D.
Address 4616 Edmondson Ave Date signed 12/9/46

DOGARIN

G46346 BALTIMORE CITY HEALTH DEPARTMENT G46346

# CERTIFICATE OF DEATH 1248 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Dukeland + Raynor
(c) Hospital or institution: West Baltimore Gen' 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 125 S. Catherine ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** (MARY DOGARIN) Amelia Mary Emilie Dogarin

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Married |

6 (b) Name of husband ~~or wife~~ Frank
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 10 | 4 | hr. min. |

9. Birthplace Hungary (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Frank Dogarin
(b) Address 125 S Catherine ST

17 (a) Buried (b) Date thereof Dec 11 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Zion Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Henry N Wright
(b) Address 4101 Edmondson Ave

19 (a) DEC 10 1946 (b)
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12-9 1946, at 12 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-25 1946, to 12-9 1946, and that I last saw h PR alive on 12-9 1946

| Immediate cause of death | Duration |
|---|---|
| – Cirrhosis of Liver | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Berdanosky M.D.
Address WBGH Date signed 12-9-46

VS 150

X

G16347 G16347

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 194a

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1118 S Kenwood Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 S. Kenwood Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Vincent Lutzzykowske

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-2339

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Lucy Lutzzykowske

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Moulder

11. Industry or business

FATHER 12. Name unknown

13. Birthplace

MOTHER 14. Maiden Name unknown

15. Birthplace

16 (a) Informant Anthony Lutzzykowski

(b) Address 1124 S Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/46 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem

Location German Hill Rd.

18 (a) Funeral director John J. Duda

(b) Address 2869 Hudson St

19 (a) DEC 10 1946 (Registrar's record of burial) Registrar

Huntington Hillsville, Md

VS 3

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 9 1946, at 1:15 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 12/6 1946 to 12/9 1946, and that I last saw h[illegible] alive on 12/9 1946.

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Matthew F. Neuendorf M. D.

Address 10765 East Ave Date signed 12/10/46

X

G46348 BC# G51961

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓64

Registered No. G46348

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town) 4H
(d) Street No. 3300- Edgerton Road. 15 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Melnick

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

(b) Name of husband or wife

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1946

8. AGE: Years | Months 4 | Days 20 2 wks | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name Irving Melnick

13. Birthplace New York

14. Maiden Name Rozalen Cohen

15. Birthplace Balto Md.

16 (a) Informant Irving Melnick

(b) Address 3300 Edgerton Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-10-46 (month) (day) (year)

(c) Cemetery or crematory

Location Wash. D.C.

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E. Balto St

19 (a) Date received by Registrar DEC 10 1946 Huntington Williams

VS 191

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10, 1946, at 8.45 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Status thymico-lymphaticus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 12-10-46

X

46349

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 168

G16349 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1223 Ashland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME William P. Lockett

(b) If veteran, name war

3 (c) Social Security Account No. 213-10-8796

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

(b) Name of husband or wife. Ethel Lockett

6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1908

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 38 | 3 | 22 | hr. min. |

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

12. Name William Joseph Lockett

13. Birthplace Va.

14. Maiden Name Ida Goodwin

15. Birthplace Va.

16 (a) Informant Ethel Lockett

(b) Address 1223 Ashland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-46 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location W. A. Co. Md.

18 (a) Funeral director Brown & Mangold & Wright

(b) Address 721 Pasquault St

DEC 10 1946 (Date rec'd by registrar)

(b) Huntington-Williams, Mgr. Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 6, 1946, at 7 A. M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull, Intracranial Hemorrhage, Laceration of brain.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 12-6-46 at 6.45 A. M.

(b) Where did injury occur? 1906 Nursery Court

(c) Did injury occur at home, on farm, industrial place, in public place? Friend's home While at work? No

(d) Means of injury Blunt force

23. Signature Homer J. Wilkie M.D. Medical Examiner.

Date signed 12-6-46

X

G16350

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46E

Registered No. G16350

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2504 Manhattan Ave.
(c) Hospital or institution:

27-19

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2504 Manhattan Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MAGGIE LEE JAMES

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9, 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 8 | 27 | hr. min. |

9. Birthplace Mathews, Va.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Thomas James
13. Birthplace Mathews, Va.

MOTHER
14. Maiden Name Margaret B. Smith
15. Birthplace Mathews, Va.

16 (a) Informant Mrs. Alexander R. James
(b) Address 2504 Manhattan Ave.

17 (a) Burial (b) Date thereof 12/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 DEC 10 1946 (b) Registrar
(Date rec'd by registrar)

V S 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 8 19 46 at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1946, to Dec. 8 1946, and that I last saw her alive on Dec. 5 1946.

| | Duration |
|---|---|
| Immediate cause of death: Cerebral Apoplexy | 3 days |
| Due to arteriosclerosis | |
| Due to – | |
| Other Conditions Malignancy of breast | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sherman R. Hantz M.D.
Address 2601 Manhattan Ave. Date signed 12/9/46

46351

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48B

Registered No. G46351

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison Street
(c) Hospital or institution:
Crawford Retreat 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 Garrison Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** LINA SCHARF

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife: Charles Scharf
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Dec. 23, 1868
8. AGE: Years 77 | Months 11 | Days 16 | If less than one day hr. min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name: Florenze Winter
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: Mrs. Robert C. Showacre
(b) Address: 2212 Garrison Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/46 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) DEC 10 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 9, 1946, at 4:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Dec 9 1946, and that I last saw her alive on Dec 9 1946.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Carcinoma of uterus | |
| Due to | |
| Other Conditions Arteriosclerotic Cardiovascular Renal dis. | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. Shorofsky M.D.
Address 601 N. Broadway Date signed 12/10/46 M. D.

V S 190

G46352

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1946

Registered No. G46352

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1810 Harlem Ave.
(c) Hospital or institution:

16-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 Harlem Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** AGNES M. ANDERSON

3 (b) If veteran, name war: no

3 (c) Social Security Account No. no

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1855

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 91 | 8 | 27 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired School Teacher
11. Industry or business

FATHER
12. Name John Anderson
13. Birthplace Unknown

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Unknown

16 (a) Informant Mrs. Philip J. Ganzert
(b) Address 3804 Fulton St., N. W. Wash, D.C.

17 (a) Cremation (b) Date thereof 12/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Crematory
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 10 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 9, 1946, at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to Dec 9 1946 and that I last saw her alive on Dec 9 1946

Immediate cause of death: Cardio-vascular - Hypertensive disease — Duration: 12 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Homer A. Todd M. D.
Address 2108 St Paul St. Date signed 12/10/46

V S 150

X

LaCo. 5-31 2500

# HEALTH DEPARTMENT—CITY OF BALTIMORE

G46353 G46353

## CERTIFICATE OF DEATH ✓937

1. PLACE OF DEATH

Registered No.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2926 Arlington Ave. St., 14 Ward)

Length of residence in city or town where death occurred 58 yrs. 4 mos. 11 ds. How long in U.S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Gertrude DeSales Bosson 27-2

(a) Residence: No. 2926 Arlington Ave. St., 14 Ward.
(Usual place of abode) (If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. Color or Race | 5. Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Single |

6. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, year) July 27, 1888

| AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 58 | 4 | 11 | |

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Clerk

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. U.S.F.& G.

10. Date deceased last worked at this occupation (month and year) 12-7-46

11. Total time (years) spent in this occupation 28

12. BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

13. NAME James W. Bosson

14. BIRTHPLACE (city or town) Chelsea
(State or country) Mass.

15. MAIDEN NAME Mary A. Delaney

16. BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

17. INFORMANT Mrs. Margaret Castagna
(Address) 3806 Greenway

18. BURIAL, CREMATION, REMOVAL Now Cremated
Place Baltimore, Md. Date 12-11- 1946

19. UNDERTAKER John A. Moran
(Address) 42nd St. & York Rd.

20. FILED DEC 10 1946 Interment in Williamsport, Md.

### MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 12-8- 1946

22. I HEREBY CERTIFY, That I attended deceased from on 12-8-46, 19..., to ..., 19...
I last saw her alive on 12-7- 1946 death is said to have occurred on the date stated above, at 5:20 P.m.

The principal cause of death and related causes of importance were as follows:

| | Date of death |
|---|---|
| Cerebral Hemorrhage | 12-8-46 |
| | |
| | |
| | |

Other contributory causes of importance:

| | |
|---|---|
| Hypertensive heart disease | |

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ... Date of injury ..., 19...
Where did injury occur? ... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. ...
Manner of injury ...
Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? No If so, specify ...

(Signed) Jos. V. Castagna, M. D.

(Address) 104 W. Madison Street

G46354 BC# 505458 G63431

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

G46354 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 Vincent Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Baby Girl Gray @ 56343

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-25-46

8. AGE: Years | Months | Days 5 6 | If less than one day hr. min.

9. Birthplace md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Willie Lee Gray
13. Birthplace Ala.

MOTHER
14. Maiden Name Julia Mae Bryan
15. Birthplace Ala

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) DEC 9 1946 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH Dec. 4 1946 at 1.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 28 1946 to Dec 4 1946 and that I last saw h[illegible] alive on Dec 4 1946.

Immediate cause of death: Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip Thorne M. D.
Address Johns Hopkins Hosp. Date signed 12-5-46

X

VS 150

Birth Certificate

G46355 B-64182

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

Registered No. G46355

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d 6h
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County.....
(c) City or town Balto —
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4324 Berger Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

**3 (a) FULL NAME** Baby Boy Wolfe

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | — |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/4/46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 1 | hr. min. |

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name John Wolf
13. Birthplace

MOTHER
14. Maiden Name Ruby Davis
15. Birthplace South Carolina

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location.....

18 (a) Funeral director.....
(b) Address.....

19 (a) DEC 9 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 5 1946, at 1:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1946, to Dec 5 1946, and that I last saw h[illegible] alive on Dec 5 1946.

Immediate cause of death.....
Prematurity
Due to.....
Due to.....
Other Conditions.....
(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

Duration

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature J. Russell Nolan M. D.
Address.....Date signed 12-5-46

VS 150

Birth Certificate
G16356 G-64190 505888

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1574

G16356 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 Jeffrey St (or rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy Brotaley

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-5-46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 1 | hr. min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Roy Benam Brotaley
13. Birthplace Pa.

MOTHER 14. Maiden Name Betty Findley
15. Birthplace Pa

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location
18 (a) Funeral director
(b) Address
19 (a) DEC 10 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH Dec - 6 1946, at 11.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec - 5 1946 to Dec 6 1946 and that I last saw him alive on Dec - 6 1946

| Immediate cause of death | Duration |
|---|---|
| Pulmonary edema | |
| Anoxia | |
| Due to | |
| | |
| Due to | |
| | |
| Other Conditions | |
| Hypoplasia (Include pregnancy within 3 months of death) | |
| Date of operation | |
| Major findings of operations | |
| of autopsy: | |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature J. Russell Jordan M.D.
Address Date signed 12-7-46

VS 130

G46357 BCH G62920

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓159

G46357 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 7-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 Barnes Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Gloria Addison

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Black | Single |

6. (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 24, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 11 | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Richard Morton
13. Birthplace North Carolina

MOTHER
14. Maiden Name Gloria Addison
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 5 1946, at 8:25A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24 1946, to Dec. 5 1946, and that I last saw h.im alive on Dec. 5 1946.

Immediate cause of death Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. Russell Jordan M. D.
Address Johns Hopkins Hospital Date signed 12-6-46

VS 150

Birth Certificate
G16358
D-64277

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 157E

Registered No. G16358

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Sinai Hosp.
(c) Hospital or institution: E. Monument St. 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) 1 da

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore 31
(If outside city or town limits, write RURAL and give town)
(d) Street No. 226 N. Chester
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BABY GIRL GAFF

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | wht. | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| NB | | 1 day | * hr. min. |

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Jos. Gaff
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Lillian Pugh
15. Birthplace Balto., Md

16 (a) Informant Mother's Hosp. Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 DEC 10 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27 1946, at 9:55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 26 1946 to Nov 27 1946 and that I last saw he alive on Nov 27 1946

| Immediate cause of death | Duration |
|---|---|
| Pneumonia, Lobar, failure | 1 hour |
| Due to Congenital Heart Dis. | 30 hrs. |
| Due to | |
| Other Conditions Bronchopneumonia, Cong. absence of right radius (Include pregnancy within 3 months of death) | 30 hrs |

Date of operation 11-27-46
Major findings of operation: Bronchopneumonia, aspiration - left lower all lobes.
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irwin Klaus M. D.
Address Sinai Hosp. Date signed 11-29

VS 2

G16359 Birth Certificate G-6427

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 159

G46359
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7014 P.K. Hyde Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hartz.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex W
5. Color or race
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11/16/46

8. AGE: Years W | Months | Days | If less than one day 16 hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Stanley Hartz
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Natalie ?
15. Birthplace Balto. Md.

16 (a) Informant Stanley Hartz
(b) Address 7014 P.K. Hyde Park Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address Funeral for Williams, M.D.

19 (a) DEC 10 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17, 1946 at 6:- A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 16 19 46 to Nov. 17 19 46
and that I last saw him alive on Nov. 17 19 46.

| Immediate cause of death | Duration |
|---|---|
| Prematurity | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin Seaman, M.D. M. D.
Address Sinai Hospital Date signed Nov 17 1946

VS 3

M. D. B. 1765-6

G46360 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G46360

## CERTIFICATE OF DEATH 1937

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 832 Franklintown Rd St., Ward)

Registered No.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Margaret Kemple Swoboda

(a) Residence: No. 832 Franklintown Road St., 16-b Ward.
(Usual place of abode) (If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. Color or Race | 5. Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Married |

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Paul Kemple Swoboda

6. DATE OF BIRTH (month, day, year) Feb. 12, 1873

| 7. AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 73 | 9 | 26 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Home

10. Date deceased last worked at this occupation (month and year) Dec. 1946

11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) (State or country) Cambridge, Md

FATHER

13. NAME Stephen L. Hurley

14. BIRTHPLACE (city or town) (State or country) Cambridge Md.

MOTHER

15. MAIDEN NAME Ann Ferguson

16. BIRTHPLACE (city or town) (State or country) Md.

17. INFORMANT John H. S. Leak

(Address) 2664 W. Franklin St.

18. BURIAL, CREMATION, OR REMOVAL

Place Western Cemetery Date 12-12- 19[illegible]

19. UNDERTAKER Wilbur W. Shivers Inc.

(Address) 4430 Edmondson Ave

20. FILED 19

DEC 10 1946 Registrar.

Huntington Williams, M.D.

### MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Dec. 8, 1946

22. I HEREBY CERTIFY, That I attended deceased from December 7, 1946, to December 8, 1946

I last saw her alive on December 8, 1946 Death is said to have occurred on the date stated above, at 5:25 A.M.

The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Cerebral Hemorrhage | 1 day Dec. 7, 1946 |
| | |
| | |
| | |
| | |

Other contributory causes of importance:

| | |
|---|---|
| Hypertension Cardio-Vascular Disease | ? |
| Generalized Arteriosclerosis | ? |

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) Philip F. Lerner M. D.

(Address) 2401 E. North Ave.

X

6361

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 616361

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital. 11-D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 East Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul L. Aschleman

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, ~~married, widowed, or divorced~~ Single
(b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 15, 1884
8. AGE: Years 62 | Months 9/10 | Days 24 | If less than one day hr. min.
9. Birthplace Woodland Co- Me
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

12. Name Philip Aschleman
13. Birthplace Switzerland
14. Maiden Name Anna Winger
15. Birthplace Switzerland

16 (a) Informant Sidel Funeral Home
(b) Address Rankins, Ill.

17 (a) Removal (b) Date thereof 12-10-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rankins
Location Rankins Ill

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 DEC 10 1946 (b) Huntington, W. Va. Received, Ill.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9, 1946, at 11.05 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Syphilitic aortitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12-9-46

16362

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V171a

G16362 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: East Baltimore General 15 10 dea
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3901 Dorchester Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY C. MURPHY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Peter E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-5-1870

8. AGE: Years 76 | Months 0 | Days 2 | If less than one day hr. min.

9. Birthplace Balto City (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business Home

12. Name Ferdinand Sommers

13. Birthplace Balto. Md.

14. Maiden Name Ella DINSMORE

15. Birthplace Balto Md.

16 (a) Informant Mrs. Charles Murphy Wife

(b) Address 6645 Georgia Ave Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-46 (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cem.

Location HARford Rd. Baltimore City

18 (a) Funeral director G. Vernon Lehmann

(b) Address 4611 Park Heights Av.

19 (a) (Date received by Registrar) (b) Washington Williams, M.D. Registrar

DEC 10 1946

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-7-1946, at 1 55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fractured skull
Intracranial hemorrhage
Contusion of brain
Fractured ribs
Other Conditions Fractured pelvis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1:30 P.M. at 12-7-46 15/10 M.
(b) Where did injury occur? Burrington Rd + Edgewood
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by Street car

23. Signature George E. Merrill M.D. Medical Examiner.
Date signed 12/9/46

X

G16363 Birth Certificate 64205

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

Registered No. G16363

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address MERCY HOSPI.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County BALTO.
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. BOX 192 A ROUTE 15 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BABY BEATTY

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: 5 hr. min.

9. Birthplace BALTO. - MD (Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER — 12. Name WOODROW BEATTY
13. Birthplace BALTO. -

MOTHER — 14. Maiden Name MRS. EVELYN BAIER.
15. Birthplace ?

16 (a) Informant MR. WOODROW BEATTY
(b) Address BOX 192A. ROUTE 15, BALTO, CO

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-11-46 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location

18 (a) Funeral director J. LESTON WIEDEFELD
(b) Address 501 E. 32ND ST

19 DEC 10 1946 (Date rec'd by local reg.) (b) Huntington Wil... (Address), MD

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/10 1946, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/9 1946 to 12/10 1946, and that I last saw h[illegible] alive on 12/10 1946

| Immediate cause of death | Duration |
|---|---|
| ATELECTASIS | |
| Due to PREMATURITY | |
| Due to MUCUS PLUG IN LUNGS | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dwight P. Cruikshank M.D.
Address MERCY HOSP. BALTO Date signed 12/11/46

VS 150

16364

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1469

G46364 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + 34th Sts.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County -
(c) City or town BALTIMORE-10
(If outside city or town limits, write RURAL and give town)
(d) Street No. WARRENTON APTS
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] BREWSTER, III (ELIZABETH Baugh)

3 (b) If veteran, name war —
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | W |

6 (b) Name of husband or wife BENJAMIN H. BREWSTER JR (D)
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9-16-1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 3 | 26 | hr. min. |

9. Birthplace PENNSYLVANIA (Town, county, and state)
10. Usual Occupation NONE.
11. Industry or business -

FATHER
12. Name DANIEL BAUGH
13. Birthplace PENNSYLVANIA

MOTHER
14. Maiden Name ANN HUNTER WILLS
15. Birthplace PENNSYLVANIA

16 (a) Informant B.H. BREWSTER III
(b) Address TOWSON, MD.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof DEC 11 1946 (month) (day) (year)
(c) Cemetery or crematory St Thomas
Location Davidson Forest Md

18 (a) Funeral director Henry W. Jenkins Sons
(b) Address Mt Auburn & Brehms Lane

19 DEC 10 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-10 1946 at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-25 1946 to 12-10 1946 and that I last saw h[illegible] alive on 12-10 1946

Immediate cause of death Respiratory Paralysis — Duration 2 Days

Due to Carcinoma of Pancreas — 7

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation 12-5-46

Major findings of operation: Ca of Pancreas Generalized Carcinomatosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury
29. Signature [signature]
Address Union Memorial Hosp Date signed 12/10/46

VS 150

G46365

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G46365

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 N. Beechwood Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Julie Helen McColgan

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widowed |

6 (b) Name of husband or wife Edw. McColgan
6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 1 | 3 | hr. min. |

9. Birthplace Balto., Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

**FATHER**
12. Name Eugene P. Vaughan
13. Birthplace New York

**MOTHER**
14. Maiden Name Mary Ward
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Helen McColgan
(b) Address 206 N. Beechwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 11 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address McCulloh & Orchard Sts.

19 (a) DEC 10 1946 (Date rec'd by registrar) (b) Huntington Hill Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12-8-46 1946, at 1:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1946 to Dec 8 1946 and that I last saw h[illegible] alive on Dec 8 1946

Immediate cause of death Respiratory Failure — Duration

Due to Chronic Heart Disease

Due to Chronic Asthma

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James V. Munor Jr.
Address Mercy Hosp. Date signed M. 12 D. 9/46

VS 150

6366

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 157M

Registered No. G16366

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Fredk County
(c) City or town Knoxville,
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

**3 (a) FULL NAME** Nancy Ella Sullivan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-8-1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 2 | hr. min. |

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name James Sullivan
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Thompson
15. Birthplace Md.

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 13 1946 (month) (day) (year)
(c) Cemetery or crematory Bark Hughs
Location Brunswick Md

18 (a) Funeral director C. H. Fritz & Bro.
(b) Address Brunswick Md

19 DEC 10 1946 (Date and by registrar) Written for Williamsport

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Dec 10, 1946, at 7.55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1946 to Dec 10 1946 and that I last saw h.er alive on Dec 10 1946.

| Immediate cause of death | Duration |
|---|---|
| CONGENITAL DIAPHRAGMATIC HERNIA | LIFE |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Paul H. Mendon M. D.
Address Johns Hopkins Hosp. Date signed 12/10/46.

VS 150

X

G16367

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

Registered No. G16367

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Cabot ct Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State ✓ (b) County Carroll
(c) City or town Westminster Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 50 John St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Francis Phillips

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. 213-24-7896 |
|---|---|

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | married |

6 (b) Name of husband or wife Lillie Phillips
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 21 Aug 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 3 4 | 22 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

**FATHER**
12. Name Louis Phillips
13. Birthplace Maryland

**MOTHER**
14. Maiden Name Elizabeth Phillips
15. Birthplace Maryland

16 (a) Informant Mrs. Edna Mae Blogger
(b) Address 50 John St. Westminster Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 13/46 (month) (day) (year)
(c) Cemetery or crematory Druid Park Cem.
Location Annalwood Carroll Co. Md.

18 (a) Funeral director Jos. E. Myers Jr.
(b) Address Westminster Md.

DEC 11 1946 (Date rec'd by registrar) (b) Clayton Williams Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 10 Dec 1946, at 4:40 PM

**21.** I certify that death occurred on the date above stated; that I attended deceased from 10 Dec 1946 to 19..., and that I last saw h[im] alive on 10 Dec 1946 3.50 PM

| Immediate cause of death | Duration |
|---|---|
| Cardiac Decompensation | 3 mos |
| Due to Arterio sclerotic Heart Disease | 2 years |
| Due to | |
| Other Conditions Jaundice | 1 week |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward L. McCabe M.D. M. D.
Address Mercy Hospital Balt. Date signed 10 Dec '46

VS 150

6368

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

30c

G16368 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Turney, Edward William

3 (b) If veteran, name war

3 (c) Social Security Account No. 456-16-4119

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Jane Myers Turney

6 (c) If alive, give age 21 years

7. Birth date of deceased (mo., day, yr.) March 29, 1911

8. AGE: Years 35 | Months 8 | Days 10 11 | If less than one day hr. min.

9. Birthplace Portage, Pa.
(Town, county, and state)

10. Usual Occupation Chief electrician

11. Industry or business Seafarer

FATHER
12. Name Edward K. Turney
13. Birthplace Pa.

MOTHER
14. Maiden Name Bertha ?
15. Birthplace Pa.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 12, 46 (month) (day) (year)
(c) Cemetery or crematory Portage
Location Portage Pa.

18 (a) Funeral director John O. Mitchell Home
(b) Address 1900 Eutaw Place

19 DEC 11 1946 (Date rec'd by registrar) (c) Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9 1946, at 8:27 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1946 to Dec. 9 1946 and that I last saw him alive on Dec. 9 1946.

Immediate cause of death Hemorrhage, cerebral. — Duration 3 wks.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy As above

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 12/9/46 M.D.

16369

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1634

Registered No. G16369

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1803 Presbury st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 Presbury St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond A Plant.

(b) If veteran, name war —

3 (c) Social Security Account No. 213-10-4232

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

(b) Name of husband or wife Lena C

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 15, 1889

8. AGE: Years 57 | Months - | Days 25 | If less than one day ____hr. ____min.

9. Birthplace Rochester N Y
(Town, county, and state)

10. Usual Occupation Storm Fitter

11. Industry or business General Motors

12. Name Charles Plant

13. Birthplace N Y

14. Maiden Name Josephine Chamberlain

15. Birthplace N Y

16 (a) Informant Mrs Lena C Plant

(b) Address 1803 Presbury St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/46 (month) (day) (year)

(c) Cemetery or crematory Green Mount

Location Baltimore Md

18 (a) Funeral director Wilson Cobb Inc

(b) Address 1217 E Fort Ave

19 (a) ____ (Date rec'd by registrar) (b) Huntingtown Williamsport Md Register's

DEC 11 1946

Vs 161

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-10- 1946, at 12 30 P. M

21. I certify that I took charge of the remains described above, held an Autopsy & Insp. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Illuminating Gas.

Other Conditions Carcinoma of urinary bladder.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-10-46 at 11 a. M.
(b) Where did injury occur? 1803 Presbury st.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Burners of Baltimore Gas heater open + unlit

23. Signature Howard J. Mowbray M.D.
Medical Examiner.

Date signed 12-10-46

X

G16370

TM. 106115

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1/61

Registered No. G16370

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 734 E. Biddle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Heltzel

3 (b) If veteran, name war N

3 (c) Social Security Account No. NMF

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4th 1879

8. AGE: Years 67 | Months 8 | Days 6 | If less than one day ....hr. ....min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Hugh Doyle
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary LUTTON
15. Birthplace Pa.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records )

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/46 (month) (day) (year)
(c) Cemetery or crematory Gibson M.E.
Location Long Green Md

18 (a) Funeral director J. Tillman Coale
(b) Address 1219 E. Fayette St

DEC 11 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** December 10th 1946, at 12.45 M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Nov. 15th 1946 to Dec. 10 1946 and that I last saw her alive on Dec 10th 1946.

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia | |
| Due to | |
| Due to | |
| Other Conditions: Generalized arteriosclerosis, Diabetes Mellitus (Include pregnancy within 3 months of death) | |

Date of operation 11/13/46
Major findings of operation: Diabetic gangrene left foot.
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23. Signature** H. H. Gibbs M. D.
Address Baltimore City Hosp. Date signed 12/10/46

63 W.1 George Zimmerman
2858 Harford Road

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 54 B

G46371

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2703 Grindon Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2703 Grindon Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Otto James Hentschel

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Elizabeth M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1901

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 45 | 6 | 27 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Paul A. Hentschel
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Rolle
15. Birthplace Germany

16 (a) Informant Mrs. Elizabeth M. Hentschel
(b) Address 2703 Grindon Avenue

17 (a) Burial (b) Date thereof 12/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) Dec 11 1946 Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8, 1946, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Dec 8 1946 and that I last saw her alive on Dec 7 1946.

Immediate cause of death Cancer of the Brain — Duration 3 yrs
Due to —
Due to —
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 1942
Major findings of operation: Tumor of Brain
of autopsy

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. L. Zimmerman M. D.
Address 2858 Harford Rd Date signed 12-10/46

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

6372

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G46372 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4301 Reisterstown Road.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 13
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4301 Reisterstown Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE STEINBACH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. DIVORCED

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 31, 1876

8. AGE: Years 70 | Months 8 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business NONE

FATHER
12. Name — BECK
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant MRS. ROSE NAGEL
(b) Address 525 S. BENTALOU ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12 11 46 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location FREDERICK RD.

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST.

DEC 11 1946 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10, 1946, at M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Date signed 12-10-46 Medical Examiner.

VS 151

16373

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93E

Registered No. C16373

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2627 N. Hilton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2627 N. Hilton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** PETER HOFFMAN

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widower |

6 (b) Name of husband or wife Carolina C. Hoffman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1862

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 84 | 1 | 29 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Henry Hoffman
13. Birthplace Md.

MOTHER
14. Maiden Name Not Known
15. Birthplace "

16 (a) Informant Mrs. Louise Knight, Daughter
(b) Address 2627 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 11 1946 (Date rec'd by registrar) Registrar

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-7-46 19 to 12-9 1946, and that I last saw him alive on 12-9-1946

| Immediate cause of death | Duration |
|---|---|
| Acute Congestive heart failure | 2 days |
| Due to Arteriosclerosis | 5 yrs. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward H. McGinnis M. D.
Address 3604 Garrison Blvd Date signed 12-10-46

16374 Barber X

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 10

Registered No. G16374

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Harford Rd + Herring Run
(c) Hospital or institution:
Lyndenhurst Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Harford
(c) City or town Whiteford
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Richard Joseph Barber ✓

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| — | — |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1945

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 1 | 6 | 18 | hr. min. |

9. Birthplace Whiteford, Harford Co., Md.
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business —

FATHER
12. Name Charles Edward Barber
13. Birthplace Whiteford, Md.

MOTHER
14. Maiden Name Margaret Thompson
15. Birthplace Tazewell, Virginia

16 (a) Informant Charles Edward Barber
(b) Address Whiteford, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Ridge Cem.
Location Delta P.O., Cardiff Md.
18 (a) Funeral director Chas. E. Powell
(b) Address 2427 Edmondson Ave.
19 (a) DEC 11 1946 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 11 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1946 to Dec 11 1946, and that I last saw him alive on Dec 11 1946.

Immediate cause of death Respiratory failure — Duration —
Due to Pneumothorax + pneumonitis —
Due to Diphtheria —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Richard E. Drummond, M.D. M. D.
Address Lyndenhurst Hospital Date signed 12/11/46

V S 150

383212 Holzer X G46375

G46375

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 157E

Registered No. G46375

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

**2. USUAL RESIDENCE OF DECEASED:**
(a) State N. J. (b) County
(c) City or town Pleasantville (If outside city or town limits, write RURAL and give town)
(d) Street No. 120 W. Mulberry (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Jules Holzer

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| N | [illegible] |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-12-29

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 17 | 3 | 28 | hr. min. |

9. Birthplace N. J. (Town, county, and state)
10. Usual Occupation school student
11. Industry or business

**FATHER**
12. Name Julius Holzer
13. Birthplace N. J.

**MOTHER**
14. Maiden Name Mildred Field
15. Birthplace N. J.

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial [illegible] (Burial, cremation, or removal) (b) Date thereof 12/11/46 (month) (day) (year)
(c) Cemetery or crematory SOMERS Point
Location SOMERS Point N.J.

18 (a) Funeral director Wilson & Son
(b) Address 129 W Pont St

19 (a) 12-11-1946 (Registrar) (b) [illegible]

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1946, at 3:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1946, to Dec 10 1946, and that I last saw him alive on Dec 10 1946

Immediate cause of death Congenital heart disease (Tetralogy of Fallot) — Duration Life

Due to

Due to

Other Conditions Post-operative pneumothorax — 1 day

(Include pregnancy within 3 months of death)

Date of operation Dec 9 1946

Major findings of operation: Pulmonary stenosis, right ventricle

of autopsy: None

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry T. Bahnson M. D.
Address Johns Hopkins Hosp. Date signed 12/14/46

VS 150

G46376

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 1937

G46376 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts 6th Flr
(c) Hospital or institution Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County —
(c) City or town Baltimore 14
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3005 Pinewood Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

**3 (a) FULL NAME** Mrs. Rachel N. [redacted] Miller

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| — | — |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Widowed |

6 (b) Name of husband or wife Robert E. Miller
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 15, 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 0 | 25 | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

**FATHER**
12. Name William J. Nicoll
13. Birthplace Baltimore, Maryland

**MOTHER**
14. Maiden Name Agnes Batchelder
15. Birthplace Philadelphia, Pa.

16 (a) Informant James J. Nicoll, MD
(b) Address Mercy Hospital
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood.
Location Baltimore
18 (a) Funeral director Leonard J. Lynch
(b) Address 5305 Harford Rd.
19 (a) Date received by registrar 12/13/1946 (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 10 Dec 1946 at M
21. I certify that death occurred on the date above stated; that I attended deceased from 5 Dec 1946 to 10 Dec 1946 and that I last saw h er alive on 10 Dec 1946.

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure | |
| Due to Coronary thrombosis | |
| Due to Arteriosclerotic Cardio Vascular disease | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation —
Was there autopsy? (Yes or No) Myocardial infarction

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —
23. Signature James J. Nicoll, M.D.
Address Mercy Hosp., Balto, Md. Date signed 12 Dec 46

VS 150

Dr. Singer
1650 E. North Ave

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

587

G16377 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2536 Robb Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2536 Robb Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Laura Mae Crofoot

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1933

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 13 | 5 | 29 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at school
11. Industry or business

FATHER
12. Name Clarence C. Crofoot
13. Birthplace Md.

MOTHER
14. Maiden Name Sara Bianco
15. Birthplace Italy

16 (a) Informant Mrs. Sara Crofoot
(b) Address 2536 Robb Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 9th, 1946, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1944 to Dec. 9, 1946, and that I last saw h.e. alive on Dec. 9 1946

| Immediate cause of death | Duration |
|---|---|
| Rheumatic heart disease & failure | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jacob J. Singer M.D.
Address 506 S. Monroe St. Date signed 12-11-46

VS 150

X

16378 BALTIMORE CITY HEALTH DEPARTMENT G16378

# CERTIFICATE OF DEATH 146E

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4018 Carlisle ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4018 Carlisle ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Hannah Kruger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Benjamine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 48 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Jacob Zemil
13. Birthplace Russia

MOTHER 14. Maiden Name Ida
15. Birthplace Russia

16 (a) Informant Benj. Kruger
(b) Address 4018 Carlisle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philp Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1539 E Baltimore St

19 (a) DEC 11 1946 (Date rec'd by registrar) Registrar for Baltimore, Md.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12-11-1946, at 5A 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to 12-10 1946 and that I last saw h alive on 12-10 1946.

Immediate cause of death: Carcinoma of Descending Colon — Duration 1 YR (?)
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation May 1, 1946
Major findings of operation: Inoperable Carcinoma of Descending Colon
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert J. Hunelfarb
Address 1801 Eutaw Pl. Date signed 12-11-46 M D

VS 150

16379

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 56E

Registered 16379

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days
(e) Length of stay in Baltimore (yrs., mos., or days) 33 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Pa. (b) County
(c) City or town Brownsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 225 Clover St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Rankin, Anna Mae

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife Dewey Rankin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | 9 | 15 | hr. min. |

9. Birthplace Brownsville, Pa.
(Town, county, and state)
10. Usual Occupation Stewardess
11. Industry or business Seafarer

FATHER
12. Name Harry Mc Millan
13. Birthplace Pa.

MOTHER
14. Maiden Name Jennie Kennedy
15. Birthplace Pa.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) REMOVAL (b) Date thereof 12/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory BROWNSVILLE
Location BROWNSVILLE Pa

18 (a) Funeral director Wilson & Dore
(b) Address 1212 Lt Fond St

19 DEC 11 1946 Huntington Williams, M.D.
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 10 1946, at 11:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 1946 to Dec. 10 1946 and that I last saw her alive on Dec. 10 1946.

Immediate cause of death Adenoma of right lower bronchus. — Duration 11½ hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12-10-46

[redacted] operation: Right lower end & middle lobectomies

of autopsy: None done

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place; in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 12/11/46

VS 150

X

G16380

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH √83a

Registered No. G16380

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4203 SPRINGDALE AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) √
(e) Length of stay in Baltimore (yrs., mos., or days) ✗

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2304 SOUTH RD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** FANNY L. GOODMAN

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| — | — |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| FEMALE | WHITE | WIDOW |

6 (b) Name of husband or wife GUS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | | | hr. min. |

9. Birthplace FLORIDA (Town, county, and state)
10. Usual Occupation NO.
11. Industry or business

FATHER
12. Name BERNHARD
13. Birthplace GERMANY

MOTHER
14. Maiden Name ELIZEBETH
15. Birthplace GERMANY

16 (a) Informant MRS. B. ROSENTHAL
(b) Address 2304 SOUTH RD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-12-46 (month) (day) (year)
(c) Cemetery or crematory OHEB SHALOM
Location O'DONNEL ST

18 (a) Funeral director JACK LEWIS INC.
(b) Address 2100 EUTAW PLACE

19 DEC 11 1946 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-10-46 19 at 8 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1946 to Dec 9 1946 and that I last saw her alive on Dec 9 1946

Immediate cause of death Cerebral Hemorrhage — Duration 3 days
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel H. Cohen (M.D.)
Address 5E 11 Pumlico Rd Date signed 12/10/46

VS 150

16381

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 170c

Registered No. G16381

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 27-3
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4806 Holden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Francis Myers

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-22-3056

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1-1928

8. AGE: Years 18 | Months 11 | Days 6 | If less than one day hr. min.

9. Birthplace Balto (town, county, and state)

10. Usual Occupation Upholster

11. Industry or business Carpet Cleaner

FATHER: 12. Name Edward S. Myers
13. Birthplace Balto

MOTHER: 14. Maiden Name Elonor Thelan
15. Birthplace Balto

16 (a) Informant Edward A. Myers
(b) Address 1732 Montpelier St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 12-46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto

18 (a) Funeral director Jos J Sterr & Son
(b) Address 3091 Kentucky Ave

(a) 12-11-1946 (Date rec'd by Registrar) (b) Huntington Woodstown, Md Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 7, 1946 at 11 55 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Res death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Ribs, Laceration of lungs

Due to

Other Conditions Hemothorax, Fractured collar bones, etc.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-7-46 at c. 9 95 A. 27/2 M.
(b) Where did injury occur? Monroe Ave. & Weather Blvd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury while riding bicycle struck by auto.

23. Signature Howard J. Weaver M.D. Medical Examiner.
Date signed 12-9-46

VS 151

X

6382

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1946

Registered No. CA6382

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital D.O.A. 25-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Foundr. rear 1518 Chesapeake Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELLIS WATSON
(b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race colored
6 (a) Single, married, widowed or divorced.
(b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1880
8. AGE: Years 66 Months Days If less than one day hr. min.
9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation out of work
11. Industry or business
12. Name John Watson
13. Birthplace N.C.
14. Maiden Name Ella Henry
15. Birthplace N.C.
16 (a) Informant Thomas Williams
(b) Address 3216 Remley Street
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A. B. Co. Md
18 (a) Funeral director Isaiah L Brown Son
(b) Address 1058 W Montgomery Street
DEC 11 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6, 1946 at 2.45 P.M.

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions Varicose ulcers

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mc Gee M.D. Medical Examiner.
Date signed 12-7-46

VS 181

G16383

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G16383

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: South Baltimore General

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 38 W. West St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** DORA DENT

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | M |

6 (b) Name of husband or wife Perry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15, 1893

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | 2 | 23 | hr. min. |

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thompson
13. Birthplace

MOTHER
14. Maiden Name Josephine Jones
15. Birthplace Md

16 (a) Informant Perry Dent
(b) Address 38 W West St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-12-46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Daniel L. Brown & Son
(b) Address 101 W Montgomery St

19 (a) DEC 11 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/8/46 19 at 9:00 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Weems M.D. (Medical Examiner.)
Date signed 12/10/46

VS 191

G16384 G16384

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH √95B

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3419 Hudson St — (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

**3 (a) FULL NAME** Oscar Richards

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife Ida Richards
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30-1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 7 | 10 | hr. min. |

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Odd Jobs
11. Industry or business

FATHER
12. Name Charles Richards
13. Birthplace Germany

MOTHER
14. Maiden Name Emma Fuhrath
15. Birthplace Germany

16 (a) Informant Ida Richards
(b) Address 3419 Hudson St —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 2225 Eastern Ave

18 (a) Funeral director Blaynet & Hoffman
(b) Address 1639 Broadway

19 DEC 11 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12-10 1946 at 6 55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-6 1946 to 12-10 1946 and that I last saw him alive on 12-10 1946.

| Immediate cause of death | Duration |
|---|---|
| Cerebral embolus | |
| Due to Heart failure & auricular fibrillation (stopped) | |
| Due to Rheumatic Heart disease | |
| Other Conditions Jaundice due to hepatic embolic (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emmett Driggs M. D.
Address Univ. Hosp Date signed 12-10-46

VS 150

AB-10 G46385

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46385 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DEACEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 Argyle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clea K. Pittman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Celsie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28- 1907

8. AGE: Years 39 | Months 10 | Days 11 | If less than one day hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Pittman
13. Birthplace North Carolina

MOTHER
14. Maiden Name Gray
15. Birthplace North Carolina

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Dec. 12, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Bethel, N. C.

18 (a) Funeral director Chas. A. Hall
(b) Address 1631 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION PM

20. DATE OF DEATH December 9- 1946, at 6.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-18 1946, to 12-9- 1946 and that I last saw h... alive on 12-9 1946.

Immediate cause of death Pulmonary Tuberculosis, Far Advanced — Duration 8 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Some, plus Gastric ulcer

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. D. Bird M. D.
Address Balto City Hosps Date signed 12-10-46

VS 150

G46386

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 92 B

G46386 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 703 N Mount St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 703 N. Mount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Carrie Amanda Howard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or, divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace Harford Co. Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Emanuel Lee
13. Birthplace Harford Co. Md

MOTHER
14. Maiden Name Hannah Dorcas Ligham
15. Birthplace Harford Co. Md

16 (a) Informant Emma Welch
(b) Address 703 N. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-1946 (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Abingdon, Md.

18 (a) Funeral director Wm. Geo. A. Holland
(b) Address 6131 Druid Hill Ave

19 (a) [illegible] (Date rec'd by registrar) (b) Huntington Willis [illegible]

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 1946, at 12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 23 1946, to Dec 9 1946, and that I last saw h[illegible] alive on Dec 7 1946.

| Immediate cause of death | Duration |
|---|---|
| Mitral Insufficiency | |
| Due to Arteriosclerosis | |
| Due to [illegible] | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J Edward Fisher M. D.
Address 1442 E Monument Date signed 12/19/46

VS 180

33 G16387 Dec. 16, 1913

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 95c

G16387 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) dod
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 Maryland ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Day Atterberry

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1913

8. AGE: Years 33 | Months 9MT | Days 23 | If less than one day hr. min.

9. Birthplace Anderson, S.C. (Town, county, and state)

10. Usual Occupation Maid

11. Industry or business

FATHER: 12. Name Munroe Day
13. Birthplace Anderson, S.C.

MOTHER: 14. Maiden Name Amanda Thompson
15. Birthplace Anderson S.C.

16 (a) Informant Mrs. Munroe Day
(b) Address 1817 Maryland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 12, 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Jas. Lee, N. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) 12 1946 (Date rec'd by registrar) (b) Registered for Publication Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12 9th 1946, at 10 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her. death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute dilatation of heart
Acute pulmonary edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D. Medical Examiner.
Date signed 12-10-46

VS 151

3426 Bank St. Blakeman

G46388

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48a

Registered No. G46388

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1818 Presstman Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 Presstman Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca E. Gibson

3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Clarence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 22, 1895

8. AGE: Years 51 | Months 10 | Days 17 | If less than one day hr. min.

9. Birthplace Montgomery Co. Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name Charles Thompson
13. Birthplace Virginia

MOTHER
14. Maiden Name Sarah Jones
15. Birthplace Maryland

16 (a) Informant Eartheline Curry
(b) Address 1114 W. Mosher Street

17 (a) Burial (b) Date thereof Dec. 12, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Chas. H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 9 1946, at 1.25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1946 to Dec 9 1946, and that I last saw h[illegible] alive on Dec 9 - 1946

| | Duration |
|---|---|
| Immediate cause of death Carcinoma of Cervix | |
| Due to Pulmonary Embolism | 1946 |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. J. Kaufman M. D.
Address 3426 Bank St Date signed 12/10/46

VS 150 Huntington Williams Inc

G16389 BC# B04343 BALTIMORE CITY HEALTH DEPARTMENT ✓ 66B G16389 Registered No.

# CERTIFICATE OF DEATH

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Daniel
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Virginia May Reacher

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F. | W | Single |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1944.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 2 | Two | 1 | hr. min. |

9. Birthplace St. Agnes Hospital Balto. Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Carlton P. Reacher
13. Birthplace Virginia

MOTHER
14. Maiden Name Florence L. Hall
15. Birthplace Virginia

16 (a) Informant Mr. Carlton Reacher
(b) Address Daniels, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/46. (month) (day) (year)
(c) Cemetery or crematory St. Johns Cemetery
Location Ellicott City, Md.

18 (a) Funeral director Easton & Sons
(b) Address Ellicott City, Md.

19 (a) Date received by registrar DEC 14 1946 (b) Registrar Wellington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12-11-46 1946, at 6:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9 1946, to 12-11 1946 and that I last saw her alive on 12-10 1946.

Immediate cause of death Cardiac failure — Duration

Due to overwhelming toxemia

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

over

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. H. Vaughan Jr. M. D.
Address Union Memorial Hospital Date signed 12-14-46

VS 150

G16390

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓97

G16390 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2737 Chesterfield Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2737 Chesterfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Thomas M. Nash

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M. | W. | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1/1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 11 | 9 | hr. min. |

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Cannery

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant John Cleary - (Cousin)
(b) Address 2737 Chesterfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 12th (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Harford Rd.

18 (a) Funeral director Lilly & Zeiler
(b) Address 403 N. Wolfe St

19 (a) DEC 11 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 10 1946, at 6 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 7 1946 to Dec. 10 1946, and that I last saw h.im alive on Dec 9 1946.

| Immediate cause of death | Duration |
|---|---|
| Acute Cardiac Failure | |
| Due to arteriosclerosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward a. Flanigan Jr. M. D.
Address 3503 Fair Ave Date signed Dec 10, 46

V S 150

G16391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G16391 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2004 Bank St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore, Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2004 Bank, St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** AMANDA RINEKER

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife Henry Rineker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 6 | 13 | hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name William Lindemore
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Sophia Schauts
15. Birthplace Baltimore, Maryland

16 (a) Informant Henry Rineker
(b) Address 2004 Bank, St.

17 (a) Burial (b) Date thereof 12 14 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Rd.

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 S Wolfe, St.

19 (a) (b) Clayton Williams, M.D.
(Date rec'd by Registrar) Registrar

12 14 46

V S 190

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 10, 1946 at 9 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1946 to Dec 10 1946
and that I last saw h[illegible] alive on Dec 9 1946.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | |
| Due to Hypertension Cardiovascular Disease | |
| Due to Left Hemiplegia | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clayton Townsend M. D.
Address 2579 Eastern Ave Date signed

16392

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

Registered No. C16392

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2409 Jefferson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2409 Jefferson (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Genevieve M. Anderson

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife: William J. Anderson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 5 | 13 | hr. min. |

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business At Home

FATHER
12. Name Charles T. Phillips
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary J. Jamerson
15. Birthplace Baltimore Md

16 (a) Informant Mrs. William J. Anderson
(b) Address 2409 Jefferson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 14 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cathedral Cem.
Location 4300 Old Frederick Rd

18 (a) Funeral director Edgar W. Cauldin & Son
(b) Address 924 E. Lanvale St.

19 DEC 11 1946 (Date rec'd by Registrar) (b) Huntington Williams Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Dec 10, 1946, at 6:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10 1946 to 12/10 1946 and that I last saw h[er] alive on 12/10 1946

Immediate cause of death: Carcinoma - metastatic — Duration: 3 mo.
Due to Primary Carcinoma of Breast — 2 yr.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Joseph L. Bloom M. D.
Address 1206 E. Preston St. Date signed 12/11/46

VS 150

X

G46393 G46393

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 218 N. Durham St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 218 N. Durham St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph George Wilson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Sarah Wilson 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Whitestone Va (Town, county, and state)

10. Usual Occupation Handy Man

11. Industry or business

FATHER 12. Name George Wilson
13. Birthplace Whitestone Va.

MOTHER 14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Gladys Wilson
(b) Address 421 Barnes St.

17 (a) Burial (b) Date thereof 12/11/46 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Ave

19 (a) DEC 1 1946 (Date rec'd by registrar) (b) Huntington Wilkins, Registrar

**MEDICAL CERTIFICATION** 12/5/46 12:45 PM

20. DATE OF DEATH 12-5-46 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1-46 19 , to 12-5-46 19 , and that I last saw h/ alive on 12-4-1946

Immediate cause of death Hypostatic Congestion
Due to Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

| Duration |
|---|
| 7 |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 238 N. Collington Ave Date signed 12-10-46

VS 150

G16394 BCH BALTIMORE CITY HEALTH DEPARTMENT G16394
Registered No.

506006 G52335 CERTIFICATE OF DEATH 95a

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 100 S. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John R. Burns.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Black | — |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-26-46.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 4 | 13 | hr. min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

**FATHER**
12. Name Daniel Burns
13. Birthplace Ga.

**MOTHER**
14. Maiden Name Blanche Jones
15. Birthplace Ga.

16 (a) Informant Brenda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 12/13/46 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy B. Wilson
(b) Address 1000 Eutaw St & Ave

19 (a) 1946 (b) Huntington Williams Registrar
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 9 1946, at 10.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 6 1946, to Dec. 9 1946, and that I last saw him alive on Dec. 9 1946.

| Immediate cause of death | Duration |
|---|---|
| ACUTE CARDIAC FAILURE | 2 days |
| Due to PAROXYSMAL AURICULAR | |
| Due to TACHYCARDIA | 2 days |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
Signature Paul Mandy M. D.
Address Johns Hopkins Hosp. Date signed 12-19-46

VS 150

Paul Mandy X

G46395
AB- 106266

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 107

G46395
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 31
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 120 S. Bond Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Willian Pierce ( Peterson)

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | Married-Seperated |

6 (b) Name of husband or wife Fanny
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12- 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 8 | 26 | hr. min. |

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name William
13. Birthplace Virginia

MOTHER
14. Maiden Name Fanny ?
15. Birthplace Virginia

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Elroy A Wilson

18 (a) Funeral director
(b) Address 1000 Hartdale Ave

19 (a) 1946 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 8- 1946, at 9.55A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-21 1946 to 12-8- 1946 and that I last saw h. im alive on 12-8 1946.

| Immediate cause of death | Duration |
|---|---|
| Respiratory Failure | |
| Due to Bronchopneumonia | |
| Due to | |
| Other Conditions Generalized Arteriosclerosis | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. D. Scarborough M. D.
Address Balto City Hosp Date signed 12-8-46

VS 150

G46396

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 181

G46396 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5 W
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 34 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 304 N. High St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anna Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife: Luther Kelly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/19/1915

8. AGE: Years 31 | Months - | Days 20 | If less than one day hr. min.

9. Birthplace Mercersburg, Pa.
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER 12. Name John Tennewell

13. Birthplace Pa.

MOTHER 14. Maiden Name Nellie Tennewell

15. Birthplace Pa

16 (a) Informant Dora Tucker

(b) Address 1623 Curtis Ave., Ellwood City, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/46 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Elroy A. Wilson

(b) Address 1000 Brantly Ave.

19 (a) 12-16-1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 181

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-9 1946, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Shock
2nd & 3rd degree burns

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 12-7-46 at 12 Midnight P.M. 572

(b) Where did injury occur? 304 N. High St.

(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no

(d) Means of injury Explosion of oil stove

23. Signature Howard J. Madeira M.D.
Medical Examiner.

Date signed 12-9-46

G46397

505705

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 157E

Registered No. G46397

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Okla. (b) County.....
(c) City or town Sapulpa
(If outside city or town limits, write RURAL and give town)
(d) Street No. 509 S Poplar St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

**3 (a) FULL NAME** Jerry Bowen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 6-6-42

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 4 | 6 | 5 | ..... hr. ..... min. |

9. Birthplace Kansas.
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Sam Bowen
13. Birthplace Okla.

MOTHER
14. Maiden Name Alta Babbitt
15. Birthplace Ark.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 12/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Dunbar.
Location Waldron Ark.

18 (a) Funeral director John O Mitchell Mortuary
(b) Address 409 E Lexington St Baltimore Md

19 (a) DEC 11 1946 (b) [illegible] Registrar
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 11 1946, at 5.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 3 1946, to Dec. 11 1946 and that I last saw him alive on Dec 11 1946.

| Immediate cause of death | Duration |
|---|---|
| Congenital heart disease | |
| Circumvascular Complex | |
| Due to..... | |
| Due to..... | |
| Other Conditions Spastic hemiplegia | |

(Include pregnancy within 3 months of death)

Date of operation Dec 7, 1946
Major findings of operation: Clot pulmonary artrial pressure
of autopsy: Cong. heart disease

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Henry E. Bahman M. D.
Address Johns Hopkins Hosp. Date signed 12/11/46

VS 150

G46398 G46398

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 194a

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1910 Dillon St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1910 Dillon St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Samuel Ayres

3 (b) If veteran, name war None | 3 (c) Social Security Account No. 218-07-9997

4. Male | 5. White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Sarah Ellen Ayres

6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) Aug 6 1866

8. AGE: Years 80 | Months 6 | Days 3 | If less than one day: hr. min.

9. Birthplace Baltimore Md (town, county, and state)

10. Usual Occupation Helper - Blacksmith

11. Industry or business Emerson Saw Co

FATHER 12. Name William Samuel Ayres

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Harriet Adams

15. Birthplace Baltimore Md

16 (a) Informant William C Ayres

(b) Address 3117 Glendale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 12 1946 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem

Location Baltimore Co Md

18 (a) Funeral director E Willis Lamorray

(b) Address 4510 Liberty Hghts Ave

19 (a) Dec 11 1946 (Date received by registrar) (b) Huntington Williams, Registrar

VS 100

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 9 1946 6 35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1946, to Dec 9 1946, and that I last saw him alive on Dec 9 1946

Immediate cause of death Coronary Occlusion — Duration 1 Day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Nicoli M. D.

Address 7661 Eastern Ave Date signed 12/9/46

X

G46399

G46399

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2510 Green Mount Ave.
(c) Hospital or institution:
Southern Hos. & Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2510 Green Mount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anna M. Evans

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1851

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 95 | 5 | 19 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Charles D. Evans
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna M. Evans
15. Birthplace Balto. Md.

16 (a) Informant Southern Hos. & Home
(b) Address 2510 Green Mount Ave.

17 (a) Burial (b) Date thereof 12/12/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemy.
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) DEC 11 1946 Huntington Williams, M.D.
(Date received by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 10, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1946 to 12-10 1946 and that I last saw her alive on 12-10 1946

Immediate cause of death — Duration

Due to old age

Due to Chronic Myocarditis several years.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert C. Blake M. D.
Address Medical Arts. Bldg. Date signed

VS 150

X

16100

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 43D

Registered No. 626100

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3408 E. Baltimore St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) ~~City~~ or town Baltimore #24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3408 E. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Emma Marie Krepp

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife William Krepp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 73 | 2 | 10 | hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Martin William Schweiger
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Henrietta Brown
15. Birthplace Baltimore, Md.

16 (a) Informant Martin W. Krepp Sr.
(b) Address 4202 Kolb Ave., Baltimore, Md

17 (a) Burial (b) Date thereof 12/13/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Carmel Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) DEC 11 1946 (Date received by local registrar) Huntington Williams (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 10 1946, at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from February 1943 to Dec. 10 1946, and that I last saw her alive on 12/10 1946

| Immediate cause of death | Duration |
|---|---|
| Pulmonary edema | 72 hrs. |
| Due to Heart failure | |
| Due to Arteriosclerotic Heart Disease | 5 yrs. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin W. Krepp Sr. M.D.
Address 4202 Kolb Ave. Date signed 12/10/46

VS 150

G16401 G16401

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93E

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 702 N. Carey
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702 N. Carey
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John E. Johnson King

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| World I | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | Married |

6 (b) Name of husband or wife Bertha Hughes King
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-4-1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 6 | 5 | hr. min. |

9. Birthplace Danville Va
(Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Wade King
13. Birthplace Va.

MOTHER
14. Maiden Name Charlotte?
15. Birthplace Va

16 (a) Informant Bertha Hughes King
(b) Address 702 N. Carey St.

17 (a) Burial (b) Date thereof 12-12-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location City

18 (a) Funeral director Samuel W. Sullivan Jr.
(b) Address 1011 N. Arlington Ave

19 (a) (b) Huntington Hill Registrar
Date rec'd by registrar DEC 12 1946

VS 3

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9th 1946, at 6.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 2 1946, to Dec. 9 1946, and that I last saw him alive on Dec. 9 1946

| Immediate cause of death | Duration |
|---|---|
| Acute Coronary Occlusion | 2 days |
| Due to Myocarditis | |
| Due to | |
| Other Conditions Bronchial Asthma | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. M. Lawrence M. D.
Address 1083 W. Lanvale St. Date signed 12/10/46

X

G46102 BALTIMORE CITY HEALTH DEPARTMENT G46102
CERTIFICATE OF DEATH 937D Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 401 Warren Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 401 Warren Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Slavin

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F. | W. | W. |

6 (b) Name of husband or wife C
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8 - 1963

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 8 | 2 | hs. min. |

9. Birthplace Calvert Co. Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business —

FATHER 12. Name Franklin Hales
13. Birthplace Calvert Co. Md
MOTHER 14. Maiden Name Rebecca Stone
15. Birthplace St. Mary's Co. Md.

16 (a) Informant Mrs Laurence Mc Hugh
(b) Address 401 Warren Ave

17 (a) Burial (b) Date thereof 12-13-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1416 Light St.

19 (a) 1946 Thos. J. Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 1946, at 9 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1946, to Dec 10 1946, and that I last saw h[illegible] alive on Dec 9 1946.

Immediate cause of death Uremia due to Disufficiency. Duration

Due to

Due to

Other Conditions Arteriosclerosis Hypertension, Myocarditis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A. Schenuit M. D.
Address 1157 S. Charles St. Date signed 12/12/46.

VS 150

G16403

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

G16403 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 112 E. Fitting Pl
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 112 Fitting Pl
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Margaret E. Montgomery
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F. | W. | M. |

6 (b) Name of husband or wife Harry A.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 13 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 9 | 26 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert Michell
13. Birthplace Penna.

MOTHER
14. Maiden Name Sarah Enright
15. Birthplace —

16 (a) Informant Harry A. Montgomery
(b) Address 112 Fitting Pl.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-12-1946 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location A. A. Co. Md.

18 (a) Funeral director Floyd & Flynn
(b) Address 1426 Light St.

19 (a) (Registrar's signature) (b) Huntington Williams Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9th 1946 at 8:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1946 to Dec 9 1946 and that I last saw h alive on Dec 9 1946

| Immediate cause of death | Duration |
|---|---|
| Embolism | 4 days |
| Due to Arteriosclerosis & Chronic Nephritis | Duration |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. E. Campbell M. D.
Address 1644 Hanover Date signed 12/11/46

VS 150

G46104

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1310

G46104 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1344 Washington Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1344 Washington Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert W Matthews

3 (b) If veteran, name war no

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6, 1925

8. AGE: Years 21 Months 11 Days 4 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wilburn Matthews
13. Birthplace Cambridge Md

MOTHER
14. Maiden Name Cinetta Grazier
15. Birthplace Cambridge Md

16 (a) Informant Wilburn J Matthews
(b) Address 1344 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 (month) 12 (day) 46 (year)

(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Withers Cook Inc
(b) Address 1217 E Pratt St

19 (a) DEC 12 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 10 1946, at 6 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-8 1945 to 12-10 1946 and that I last saw h[illegible] alive on 12-10 1946

Immediate cause of death: Acute Cardiac Failure — Duration 1 da.
Due to Coronary Occlusion Renal Disease — 1 yr
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dwight L Lawkaitis M. D.
Address 1719 Washington Blvd Date signed 12/11/46

G16:05

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 108

G16:05 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Trail Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-4
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2715 Boone St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME J. EDWARD HARGEST

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-8571

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary Catherine Hargest
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7th 1887

8. AGE: Years 59 | Months 4 | Days 34 | If less than one day hr. min.

9. Birthplace Md (Town, county and state)
10. Usual Occupation Contractor
11. Industry or business Self

FATHER 12. Name Andrew Hargest
13. Birthplace Md.

MOTHER 14. Maiden Name Ella Woolen
15. Birthplace Md.

16 (a) Informant Frederick Gavin
(b) Address 3113 Royston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/46 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Parkville, Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) DEC 12 1946 (Date rec'd by registrar) Huntington Williams Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/11 1946, at 8:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10 1946, to 12/11 1946, and that I last saw him alive on 12/10 1946.

Immediate cause of death LOBAR PNEUMONIA (RIGHT) — Duration 1 DAY

Due to ACUTE ALCOHOLISM AND SUBSEQUENT DEBILITATION

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles W. Stewart Jr. M.D.
Address MD. GEN. HOSP. Date signed 12/11/46

VS 150

X

G16106 — BALTIMORE CITY HEALTH DEPARTMENT — G16106 Registered No.

# CERTIFICATE OF DEATH 83a

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Ashburton Nursing Home 24
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4210 Wentworth Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Lila A. Shriner

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Oliver G. Shriner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 4 | 25 | hr. min. |

9. Birthplace Irvington, Virginia (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name George Cox
13. Birthplace Virginia

MOTHER
14. Maiden Name Mollie B. Coppedge
15. Birthplace Virginia

16 (a) Informant Mrs. Joseph Sheppard
(b) Address 4210 Wentworth Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/46 (month) (day) (year)
(c) Cemetery or crematory Moreland Memo. Park
Location Parkville, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.

DEC 12 1946 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH December 9 1946, at 5:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-1946 to 12-9-1946 and that I last saw h[illegible] alive on 12-9-1946.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 2 days |
| Due to Hypostatic Pneumonia | 1 day |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard H. Warner M. D.
Address 2407 Garrison Blvd Date signed 12-10-46

VS 190

G46107

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

B 46407 / 94a

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett Avenue
(c) Hospital or institution:
Pine Ridge Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs. 10 mos. 23 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Tenn. (b) County
(c) City or town Clarksville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Alice Mary Russell

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widowed |

6 (b) Name of husband or wife Unknown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/10/66

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 2 | 1 | hr. min. |

9. Birthplace Clarksville Tenn.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Joseph Baillin
13. Birthplace France

MOTHER
14. Maiden Name Victorine Gallezot
15. Birthplace France

16 (a) Informant The Seton Institute
(b) Address 6420 Reisterstown Road

17 (a) Burial (b) Date thereof Dec. 12-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ?
Location Nashville - Tenn.

18 (a) Funeral director STEWART & MOWER COMPANY
(b) Address (E. J. DUGGER SUC.) 100 N. HOWARD STREET Huntington Williams, Md.

19 (a) (b) Registrar
(Date received by registrar)

DEC 12 1946

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 12/11 1946, at 9:35 AM

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 19 1943, to 12/11 1946, and that I last saw h[illegible] alive on 12/4/1946

Immediate cause of death
Asphyxia Myocardial Infarct
Due to Arteriosclerosis
Due to Senentia Praecox
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

| Duration |
|---|
| 3 YRS |
| |
| |
| 12/7/1946 |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Palagia M. D.
Address 35 N. Frederick Street Date signed

X

G46108

BALTIMORE CITY HEALTH DEPARTMENT G16108 Registered No.

# CERTIFICATE OF DEATH 183a

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1112 W Pennsylvania
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 W Pennsylvania
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Samuel L Matthews Sr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-03-7842

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | M |

6 (b) Name of husband or wife Ella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 5 1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 4 | 4 | hr. min. |

9. Birthplace West Virginia
(Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Leroy Matthews

(b) Address 115 N West (S)

17 (a) Burial (b) Date thereof 12-17-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Et

Location Balto Md

18 (a) Funeral director Pearl L Brown & Son

(b) Address 108 W Mt Royal Ave

19 (a) DEC 12 1946 (b) Registrar
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/9/46 19..., at 1:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/8 1946 to 12/9 1946 and that I last saw h alive on 12/8 1946

Immediate cause of death: Cerebral Hemorrhage — Duration 1 hours

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence 12/9/46 at 1:50 P.M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature W. A. Taylor M.D.

Address 1522 Harlem Ave Date signed 12/11/46

VS 150

G16409

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G16409 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 727 S Hanover
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 727 S Hanover (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Mary E Ross

3 (b) If veteran, name war —
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | W |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 8 | | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Wm Mann
13. Birthplace Va

MOTHER
14. Maiden Name Rachel ?
15. Birthplace Md

16 (a) Informant Mamie Patterson
(b) Address 727 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaac L Brantley
(b) Address 1054 W Montgomery St

19 (a) (Date received by local registrar) (b) Timothy Leo Williams, M.D. Registrar

DEC 14 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/10 1946, at 12 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 1946 to 12/10 1946 and that I last saw h alive on 12/9 1946

Immediate cause of death Pneumonia
Hypostatic
Due to arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1111 W Lee Date signed 12/11/46

VS 150

G46410 BALTIMORE CITY HEALTH DEPARTMENT G46410

# CERTIFICATE OF DEATH 46F

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution: Little Sisters of the Poor 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Frances Preston Whitcomb

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife Samuel Whitcomb
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 27, 1870

8. AGE: Years 76 | Months 4 3 | Days 14 | If less than one day hr. min.

9. Birthplace Harford County Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Preston
13. Birthplace ?

MOTHER 14. Maiden Name Harriette Allender
15. Birthplace ?

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 13 1946 (month) (day) (year)

(c) Cemetery or crematory Calvary Methodist
Location Harford Co. Md

18 (a) Funeral director Edna Wunderlich
(b) Address 900 E. Biddle St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 3

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec - 10 - 1946, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-1- 1946, to Dec-10 1946, and that I last saw h alive on Dec- 1946.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of Liver | 1 yr. |
| Due to | |
| Due to | |
| Other Conditions Metastasis of Lung | 1 mo. |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Ave Date signed Dec 11 1946.

X

G16111

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1946

G16111 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4502 Groveland Ave.
(c) Hospital or institution: 28

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4502 Groveland Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Jesse M. Hill. Sr

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-09-3715

4. Sex male

5. Color or race white

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Hannah F. Hill

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) February 12 - 1885

8. AGE: Years 61 | Months 9 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace Elkridge Md.
(Town, county, and state)

10. Usual Occupation Foreman of Painting

11. Industry or business Baltimore Transit Co.

FATHER
12. Name Thomas B. Hill
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Melvina —
15. Birthplace Howard Co. Md.

16 (a) Informant Hannah F. Hill
(b) Address 4502 Groveland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 13/1946 (month) (day) (year)

(c) Cemetery or crematory Laraine
Location Woodlawn Md

18 (a) Funeral director Harry N. Lancaster
(b) Address 4704 Reisterstown Rd

19 (a) DEC 12 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 10 - 1946, at 7.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 - 1941, to December 10 1946, and that I last saw h[illegible] alive on December 6-1946

| Immediate cause of death | Duration |
|---|---|
| Angina Pectoris | 6 years |
| Due to | |
| Due to | |
| Other Conditions Hypertension | unknown |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chester Riland M. D.
Address 2532 Edmondson Ave Date signed 12-16-46

G46412

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G46412

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5046 Reisterstown Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5046 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary L. Wailes

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Thomas F. Wailes
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 2 1869

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 9 | 8 | hr. min. |

9. Birthplace Uniontown Carroll Co Md
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Lutherius Pitt
13. Birthplace Carroll Co Md

MOTHER
14. Maiden Name Susanne Black
15. Birthplace Carroll Co Md

16 (a) Informant Theodore Wailes
(b) Address Garrison Blvd & Pa. R.R.

17 (a) Burial (b) Date thereof Dec 12 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Providence M.E.
Location Pimlico, Md

18 (a) Funeral director Harry N. Thomas
(b) Address 4204 Pedgewood Ave

19 (a) Dec 12 1946 (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 1946, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1946 to 12/10 1946.
and that I last saw h.e alive on 12/10 1946.

| Immediate cause of death | Duration |
|---|---|
| Coronary embolism | |
| Due to | |
| Due to | |
| Other Conditions Hypertension Blood pressure | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jno Purnell M. D.
Address 3902 Keswick Rd Date signed

L. B. 3136 X

G46113

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G46113 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 838 South Bond
(c) Hospital or institution:
3a
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 838 South Bond (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PETER WDZIECZNY

3 (b) If veteran, name war

3 (c) Social Security Account No 213098187

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1885

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Stanislaw Wdziczny
13. Birthplace Poland

MOTHER
14. Maiden Name Kowalczyk
15. Birthplace Poland

16 (a) Informant Rose Wdziczny
(b) Address 838 S. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 14/46 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1950 Eastern Ave

19 (a) DEC 12 1946 (Date rec'd by Registrar) (b) Huntingdon Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/11/46 19 , at 8:10 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH (a) Myocardiac Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Ward, M.D. Medical Examiner.
Date signed 12/11/46

VS 151

G16114

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G46114 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 DeSoto Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs Edna Kershner

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15 / 1928

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 2 | 25 | hr. min. |

9. Birthplace (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Theodore Swartzer
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs Kershner Son
(b) Address 1810 DeSoto Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/46 (month) (day) (year)
(c) Cemetery or crematory St Louis Reform Cem
Location Hagerstown Rt 40

18 (a) Funeral director Edward Taylor
(b) Address 325 Gilmor Balto

19 (a) DEC 12 1946 (Date rec'd by registrar) (b) Huntington Hilliard

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/10 19 46, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/9 19 46, to 12/10 19 46, and that I last saw h.e.r alive on 12/10 19 46.

Immediate cause of death Cardiac failure — Duration
Due to — Duration
Due to — Duration
Other Conditions — Duration
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1 E Eagle Date signed 12/11/46

X

VS 150

G16115

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G16115

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3506 Elliott St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3506 Elliott St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Eugenia Rose Lewis

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: no

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife: Michael Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 4 | 12 | hr. min. |

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Wm. Moon
13. Birthplace Balto Md

MOTHER
14. Maiden Name Sarah
15. Birthplace Balto Md

16 (a) Informant Mrs Blanche M. Russell
(b) Address 3417 Elliott St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 14 1937 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Balto

18 (a) Funeral director A Howard Evans
(b) Address 1946 Pennsylvania Ave
DEC 13 1937

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 10 1937, at 11:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1937 to Dec 11 1937 and that I last saw h alive on Dec 11 1937

Immediate cause of death: Arteriosclerotic C.V. Disease — Duration 18-2-44
Chr Myocarditis — 11-2-44
Due to Acute Coronary Thrombosis — 12-11-37
Due to
Other Conditions None
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation
of autopsy Final

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E A Schemmerhorn M. D.
Address 842 S Eutaw St Date signed 12-12-37

VS 180

G46116

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G46116

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 633 S. Lehigh St
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 633 S. Lehigh St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** Anna Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wiley Lee Bell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20 1885

8. AGE: Years: 61 | Months: 4 | Days: 21 | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: housewife

11. Industry or business

FATHER
12. Name: Thomas Ballinger
13. Birthplace: Washington D.C.

MOTHER
14. Maiden Name: unknown
15. Birthplace

16 (a) Informant: Wiley L. Bell
(b) Address: 633 S. Lehigh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/46 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cemetery
Location: Eastern Ave. Rd.

18 (a) Funeral director: John J. Duda
(b) Address: 2429 Hudson St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 3

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/11 1946, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1946, to Dec 10 1946, and that I last saw h[illegible] alive on Dec 10 1946

Immediate cause of death: Hyp. Cardiac Decompensation — Duration

Due to: Hypertensive Cardiac Vascular Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations:

Of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: L H Goodman M.D.

Address 2400 E Baltimore St Date signed 12/16/46

G16117 BC# D63805

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 160a

G16117 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution: University Hospital 16-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 wk.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 325 Marmont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Jean Marie Pettigrew

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | S |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/4/46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 7 | hr. min. |

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Charles P. Pettigrew
13. Birthplace Balto
MOTHER 14. Maiden Name Amelia Difini
15. Birthplace Balto

16 (a) Informant Hosp't Rec.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-12-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director George A. Fenby
(b) Address Fenby & Fayette

19 (a) DEC 12 1946 (Date rec'd by registrar) (b) Hunting the Williams, Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12-11 1946, at 2 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-11 1946 to 12-11 1946 and that I last saw h alive on 12-11 1946

| Immediate cause of death | Duration |
|---|---|
| Bilat. atelectasis | |
| Pneumonia | |
| Due to Aspiration | |
| Due to inter cranial hemorrhage | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. L. Shallenberger M.D.
M. D.
Address University Hospital Date signed 12-12-46

VS 150

G16118

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

G16118 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-11
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3707 Edgewood Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Celia Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Solomon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years 87 | Months 7 | Days | If less than one day: hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Ezka
13. Birthplace Lith

MOTHER
14. Maiden Name Rebecca
15. Birthplace Lith

16 (a) Informant Rebecca Cohen
(b) Address 3707 Edgewood Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-12-46 (month) (day) (year)

(c) Cemetery or crematory Hebrew Herzug Lyn
Location

18 (a) Funeral director Jack Kessler Inc
(b) Address 1409 E Balto St

19 (a) (Date mailed by Registrar) (b) Huntington Williams, M.D.

DEC 17 1946

LVS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-12 1946 at 2:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-11 1946 to 12-12 1946 and that I last saw her alive on 12-12 1946.

Immediate cause of death Cerebral Vascular Accident — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan B. Hyman M. D.
Address Sinai Hospital Date signed 12-12-46

X

G16119

505969

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V 131a

Registered No. G16119

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 726 Hollen Road (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Ruth Byrd.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | widowed. |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-21-75

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 0 | 18 | hr. min. |

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name John Byrd

13. Birthplace Md.

MOTHER

14. Maiden Name Mary Anne Bethards

15. Birthplace Md

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/46 (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) DEC 12 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 9 1946 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 7 1946, to Dec. 9 1946 and that I last saw her alive on Dec. 9 1946.

Immediate cause of death Cerebro vascular accident — Duration

Due to H.C.V.D., A.S.H.D., C.A.S.

Due to Cause undetermined Chronic nephritis?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: 12/9/46

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Robert C. Austin M. D.

Address Johns Hopkins Hosp Date signed Dec 46

**PHYSICIAN**

Underline the causes to which death should be charged statistically:

G16420

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

CHK-106498

Registered No. G16420

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1604 Fleet Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Fred Rusan

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24-1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 6 | 18 | hr. min. |

9. Birthplace Yugoslavia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Evon Rusan
13. Birthplace Yugoslavia

MOTHER
14. Maiden Name RosaSerusga
15. Birthplace Yugoslavia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 12/11/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Almas House,
Location Texas, Md.

18 (a) Funeral director John J. Connelly.
(b) Address 418 Eastern Ave.

DEC 12 1946 (b) Huntington Williams, Registrar
(Date rec'd by Registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 7 1946, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29 1946, to Dec. 7 1946 and that I last saw h. alive on Dec. 7 1946.

Immediate cause of death: Embryonal Adenocarcinoma, Liver - advanced — Duration: 2 years?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Hunt M. D.
Address Balt. City Hosp. Date signed 12-11-46

6121

BALTIMORE CITY HEALTH DEPARTMENT X

# CERTIFICATE OF DEATH 46 B

Registered No. G16121

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address FAYETTE & CALHOUN ST
(c) Hospital or institution: FRANKLIN SQUARE HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 76 YRS

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MARYLAND (b) County CARROLL
(c) City or town TANEYTOWN, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** HARRY BAUMGARDNER

3 (b) If veteran, name war: Spanish-American
3 (c) Social Security Account No.: none

4. Sex: M. | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: MARY BAUMGARDNER
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Aug 26 1870

8. AGE: Years: 76 | Months: 3 | Days: 15. | If less than one day: ____ hr. ____ min.

9. Birthplace: MARYLAND (Town, county, and state)

10. Usual Occupation: Retired - mail carrier

11. Industry or business:

FATHER
12. Name: BAUMGARDNER
13. Birthplace: MARYLAND

MOTHER
14. Maiden Name: MUSSELMAN
15. Birthplace: MARYLAND

16 (a) Informant: Franklin Square Hospital
(b) Address: Balto Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-46 (month) (day) (year)
(c) Cemetery or crematory: Lutheran Cemetery
Location: Taneytown, Md.

18 (a) Funeral director: C. A. Zeiss & Son
(b) Address: Taneytown, Md.

19 (a) DEC 12 1946 (Date rec'd by Registrar) (b) Huntington Williamsport, Md.

VS 189

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11 December 1946 at 8:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 Nov 1946 to 11 Dec 1946 and that I last saw h.i.m alive on 11 Dec. 1946

| Immediate cause of death | Duration |
|---|---|
| Metastatic Carcinoma | 4 months |
| Due to: Carcinoma of Stomach | |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)

Date of operation 29 Nov. 46

Major findings of operation: Carcinoma of pylorus & metastasis

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stanley B. Klyanowicz M. D.
Address Frankl... Sq. Hosp. Date signed 12/11/46

correct age if especially important. Physicians: please write the cause of death clearly and legibly.

G16122

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH √ 8 3a

G16122 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 38 S. High St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 38 S. High St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/10/1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | 8 | 29 | hr. min. |

9. Birthplace Richmond Va.
(Town, county, and state)
10. Usual Occupation Factory Worker
11. Industry or business Canning Industry

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Burnett Phillips
(b) Address 415 S. Dallas St.

17 (a) Burial (b) Date thereof Dec 12 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem
Location Brooklyn Md
18 (a) Funeral director Chas. B. Wilson
(b) Address 1000 Bentley Ave

19 (a) Date rec'd by Local Reg. 12-10-46 (b) Washington Williams M.D. Registrar

12/8/46 **MEDICAL CERTIFICATION** 3:45 PM

20. DATE OF DEATH December 9 1946 at 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1946 to Dec 8 1946
and that I last saw h[illegible] alive on Dec 9 1946

Immediate cause of death: Cerebral Hemorrhage.
Due to: Pulmonary edema.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

| Duration |
|---|
| 18 hrs. |
| 1 hr. |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature A. C. Burwell M. D.
Address 121 Aisquith Date signed 12-9-46

X

VS 150

G16123

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G16123

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3036 Windsor Ave.
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County ----------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3036 Windsor Ave.
(If rural give location)
(e) Citizen of foreign country? ----- (Yes or No)
If yes, name country -----

**3 (a) FULL NAME** Maria Ernestine Tiralla

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| ---------- | ---------- |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband ##### Joseph F. Tiralla
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 11 | 21 | --- hr. --- min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business ----------

MOTHER FATHER
12. Name Fielding H. Lucas
13. Birthplace Maryland
14. Maiden Name Marie Goode
15. Birthplace Maryland

16 (a) Informant J. Fielding Tiralla
(b) Address 3036 Windsor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/46 (month) (day) (year)
(c) Cemetery ###### Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. W. Meats and Son
(b) Address 805 N. Calvert St.

19 (a) ##### (b) Huntington Williams, M. D.
(Date received by ####)
DEC 12 1946
Address 11 E. Chase St Date signed Dec. 10, 46

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH DECEMBER 10 1946, at 5:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1932 to Dec 9 1946, and that I last saw h## alive on Dec 9 1946.

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | ½ hour |
| Due to arteriosclerotic Hypertensive Heart Disease | many years |
| Due to | |
| Other Conditions Chronic Cholecystitis | 15 years |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wm. J. Sullivan M. D.

G46424

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 117a

G46121 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St Agnes Hosp 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 306 E. 32nd St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anna M Rea

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | S |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | | | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Secretary
11. Industry or business

FATHER
12. Name James A. Rea
13. Birthplace Md. Ireland

MOTHER
14. Maiden Name Anna E. Leonard
15. Birthplace Md Pennsylvania

16 (a) Informant Wm. G. Rea
(b) Address 1104 Portland St. Pittsburgh

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert St.

19 (a) DEC 12 19 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/11 1946, at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10 1946, to 12/11 1946, and that I last saw her alive on 12/11 1946.

| Immediate cause of death | Duration |
|---|---|
| Anesthetic shock | |
| Due to Surgical Operation | |
| Due to Gastric Ulcer | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 12/11/46
Major findings of operation: Peptic Ulcer
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 12/11/46 at 10:30 AM
(c) Where did injury occur? Baltimore, Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital (Specify type of place) While at work? No on operating table
(e) Means of injury Anaesthesia
23. Signature W. D. Sampson M.D.
Address St Agnes Hosp. Date signed 12/14/46

G. H. Medrill MD.

VS 150

6125772

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

52 B

Registered No. G16125

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 Eutaw Pl.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Estelle Harlen

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| W | [illegible] |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-2-82

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 5 | 10 | hr. min. |

9. Birthplace W. Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Mac Radcliff
13. Birthplace W. Va.

MOTHER
14. Maiden Name Liza Sheppard
15. Birthplace W. Va.

16 (a) Informant Relative
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremated (b) Date thereof 12/13/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory North Fork
Location North Fork W. Va.

18 (a) Funeral director Pettyjohn Cook Inc
(b) Address 1214 E. Fort Ave

19 DEC 12 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 11 1946, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1946 to Dec. 11 1946, and that I last saw h.m. alive on Dec. 11 1946.

Immediate cause of death ? Coronary occlusion — Duration
Due to
Due to Advanced Carcinoma Bladder
Other Conditions Agotenia
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Felix Rutledge M. D.
Address Johns Hopkins Hospital Date signed 12/11/46

X

Correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS 150

G46126

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 310

G46126 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 701 N. Glover St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 N. Glover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred J. Woolley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Louise Woolley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10th 1880

8. AGE: Years 66 | Months 5 | Days - | If less than one day hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER - FATHER

12. Name —

13. Birthplace Ireland

14. Maiden Name Elizabeth Reardon

15. Birthplace Ireland

16 (a) Informant Louise Woolley.

(b) Address 701 N. Glover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 13th 1946 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director Leo G. Cook

(b) Address 1701-03 N. Patterson Park Ave

19 (a) (b) Huntington Williams, M.D.
(Date filed by registrar)

DEC 12 1946

VS 150 Dr Grossman

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10th 1946, at 1030 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/10 1946, to 12/10 1946 and that I last saw h was alive on 12/7 1946

Immediate cause of death: Luetic Cardio vascular Disease with aortic aneurysm ruptured Coronary artery

Duration: 6 yrs ?

Due to sclerosis secondary to luetic aortitis with coronary infarction

Other Conditio

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 8 at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Karl Grossman M. D.

Address 12123 Patterson Pk Ave Date signed 12/10/46

X

G16127

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46F

Registered No. G16127

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2009 E. Oliver St.
(c) Hospital or institution:
8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 E. Oliver St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** James Moffett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Madeline Moffett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 21st 1892

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 | | | hr. min. |

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Collector
11. Industry or business Water Dept

FATHER
12. Name Patrick Moffett
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Rollin
15. Birthplace Ireland

16 (a) Informant Mrs Madeline Moffett
(b) Address 2009 E. Oliver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 14th 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo S. Leo ok
(b) Address 1201-03 N. Patterson Park Ave

19 (a) DEC 12 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150 Dr Pokorny.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10th 1946, at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 22 1946 to Dec 10 1946 and that I last saw him alive on Dec 8 1946

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of Liver | ? |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Pokorny M. D.
Address 2200 E Madison St Date signed 12/11/46

X

G16128

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 94a

Registered No. G16128

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1422 Ward St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1422 Ward St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Preston C. Wicks

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Col. | Married |

6 (b) Name of husband or wife Bertha Wicks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 10 | 1 | hr. min. |

9. Birthplace Kent Co. Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name
13. Birthplace Kent Co. Md.

MOTHER
14. Maiden Name Martha
15. Birthplace Kent Co. Md

16 (a) Informant Bertha Wicks
(b) Address 1422 Ward St

17 (a) Burial (b) Date thereof Dec. 13, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem
Location

18 (a) Funeral director Mrs. Katie P. Williams
(b) Address 322 N. Schroeder St

19 (a) (Date received by Registrar) DEC 10 1946 (b) Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 1946, at 9:50 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5 1946 to Dec 9 1946 and that I last saw h. alive on Dec 9 1946

| Immediate cause of death | Duration |
|---|---|
| Coronary Occlusion | 12 hrs. |
| Due to Coronary thrombosis and arteriosclerosis | 4 days |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John P. Wicks Jr
Address 1422 Ward St Date signed 12/12/46 M. D.

V S 150

6129

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. G16129

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 315 N. Fremont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 315 N. Fremont Ave.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

**3 (a) FULL NAME** Sarah Benson Gross

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Col. | Widow |

6 (b) Name of husband or wife Ellis Gross
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1901

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 45 | 3 | 3 | hr. min. |

9. Birthplace Calvert Co. Md.
(Town, county and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name William Gross
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Susie Hartman
15. Birthplace Calvert Co. Md

16 (a) Informant Daisy Watts
(b) Address 742 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 12, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Wm. Katie R. Williams
(b) Address 322 N. Eutaw St.

19 (a) DEC 12 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec - 10 1946, at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1946 to 12/10 1946 and that I last saw her alive on 12/9 1946.

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia | |
| Myocarditis | |
| Due to Arteriosclerosis | |
| Due to Hypertension | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury
23. Signature W. Saunders M.D.
Address 1211 Eutaw Date signed 12/10/46

V S 150

G46430

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

Registered No. G16430

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 116 E CLEMENT ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 E CLEMEIVT ST. (3)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH. B. THUMAN

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced WIDOWED

6 (b) Name of husband or wife MARY H THUMAN
6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) FEB-28 186

8. AGE: Years 85 | Months 9 | Days 13 | If less than one day hr. min.

9. Birthplace BALTIMORE MD
(Town, county, and state)

10. Usual Occupation RETIRED CARPENTER

11. Industry or business

FATHER
12. Name JOSEPH B THUMAN
13. Birthplace GERMANY

MOTHER
14. Maiden Name NOT KNOWN.
15. Birthplace NOT KNOWN

16 (a) Informant FLORENCE THUMAN
(b) Address 116 E CLEMENT ST

17 (a) BURIAL (b) Date thereof DEC 13-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location A. A. Co.

18. (a) Funeral director Bernard C Hanlon
(b) Address 121 E West St

19. DEC 12 1946 (b) Franklin for Williams
(Date rec'd by registrar)

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 10 1946 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10 1946 to 12/10 1946 and that I last saw h alive on 12/10 1946.

Immediate cause of death
Pulmonary Embolism
Cerebro Vascular Disease

Duration 6 hours

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 107 E. West St Date signed 12/12/46

X

G46431

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1946

Registered No. G46431

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 933 Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County none
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 933 Park ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Estelle Lee Van Waters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Arnold Waters
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) 2-2-89

8. AGE: Years 57 | Months 10 | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace Balto., Md
(Town, county, and state)

10. Usual Occupation none (Housewife)

11. Industry or business

FATHER 12. Name Robert C. Chase
13. Birthplace A.A. Co., Md.

MOTHER 14. Maiden Name Georgiana Atkins
15. Birthplace Balto., Md.

16 (a) Informant Arnold Waters
(b) Address 933 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-46 (month) (day) (year)
(c) Cemetery or crematory Hunters Lane Sta.
Location Hunters, Md.

18 (a) Funeral director Charles R. Law
(b) Address 802 Mad. Ave.

19 (a) ____ (b) Huntington-Williams, M.D. Registrar

DEC 12 1946
VS 160

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 12-10 1946, at 5 00 M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 8-10 1946, to 12-10 1946 and that I last saw h alive on 12-10 1946.

Immediate cause of death: Coronary Thrombosis — Duration 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23.** Signature M. D.
Address 821 Eutaw St. Date signed 12-13-46

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G46432

BALTIMORE CITY HEALTH DEPARTMENT X.

# CERTIFICATE OF DEATH 1312

Registered No. G46432

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Mich. (b) County
(c) City or town Grosse Pointe Woods
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1993 Hawthorne Rd. (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Italy

**3 (a) FULL NAME** Distefano, John Lobello

3 (b) If veteran, name war

3 (c) Social Security Account No. 050-12-2577

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | 10 | 20 | hr. min. |

9. Birthplace Sicily, Italy (Town, county, and state)
10. Usual Occupation oiler
11. Industry or business Seafarer

FATHER
12. Name Jim Distefano
13. Birthplace Sicily, Italy

MOTHER
14. Maiden Name Lenora Lebello
15. Birthplace Sicily, Italy

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 13-1946 (month) (day) (year)
(c) Cemetery or crematory Govans Presbyterian
Location Balto. Md.
18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave
19 DEC 12 1946 (Date rec'd by registrar) (b) Huntington Williams, Md. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 8 1946, at 11:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30 1946, to Dec. 8 1946 and that I last saw him alive on Dec. 8 1946

Immediate cause of death Tuberculosis, pulmonary bilateral, far advanced. — Duration: Unknown
(2) ~~Tuberculous meningitis~~ Acute meningitis, etiology undetermined. — Duration: Unknown
Due to
Other Conditions — Duration: over
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 12/10/46

Correct age is especially important. Physicians, please write plainly.

VS 150

G16433

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 194a

Registered No. G16433

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5712 Roland Avenue
(c) Hospital or institution:
Monastery of the Visitation 27-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 49 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5712 Roland Avenue
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

**3 (a) FULL NAME** Sister Mary Paulina Fitzgerald

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife --------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 0 | 21 | --hr. --min. |

9. Birthplace Knoxville, Tenn.
(Town, county, and state)
10. Usual Occupation Religious
11. Industry or business -------

FATHER
12. Name Thomas D. Fitzgerald
13. Birthplace Ireland

MOTHER
14. Maiden Name Hannah -------
15. Birthplace Ireland

16 (a) Informant Mother Mary Gertrude Peter
(b) Address 5712 Roland Avenue

17 (a) Burial (b) Date thereof 12/13/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meeter and Son
(b) Address 805 N. Calvert Street

19 (a) ..... (b) .....
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 13 1946, at 3 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to Dec 1946 and that I last saw h[illegible] alive on Dec 10 1946.

Immediate cause of death: Ac. Myocardial Infarction, 1 hr. — Duration

Due to .....

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: —

of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Charles B. Morrah M. D.
Address 5 E. Read St Date signed Dec 13

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Birth Certificate
G-64618

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 30F

Registered No. G16434

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Eden Sts.
(c) Hospital or institution: University Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 50 minutes
(e) Length of stay in Baltimore (yrs., mos., or days) 50 minutes

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2622 Pierpont St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Weems

3 (b) If veteran, name war: None
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1946

8. AGE: Years 0 | Months 0 | Days 0 | If less than one day: 0 hr. 56 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Ernest Theron Weems
13. Birthplace Annapolis, Md.

MOTHER
14. Maiden Name Irene Juanita Wallace
15. Birthplace Gastonia, N.C.

16 (a) Informant Nancy Weems
(b) Address 2622 Pierpont St. Baltimore.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 12 1946

18 (a) Funeral director Commissioner of Health
(b) Address

DEC 12 1946 (Date filed by registrar) (b) Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6 1946, at 1:15 a.m. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6 1946, to Dec 6 1946, and that I last saw her alive on Dec. 6 1946.

Immediate cause of death Anoxia — Duration

Due to Poor respiratory function — Due to Congenital Syphilis

Other Conditions Inversion of Child.
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. B. Levy M.D.
Address University Hospital Date signed 12-6-46

Birth certificate
G16135 G-64824

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓160a

Registered No. G16135

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 893 Boyd Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-3
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 893 Boyd St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Armen Lee Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Black | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 10, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| — | | 1 | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name William Patrick Jones
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Gladys Elizabeth Conner
15. Birthplace Baltimore Maryland

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory University Medical School DEC 12 1946
Location Commissioner of Health

18 (a) Funeral director
(b) Address
(c) (Date received by registrar) Huntington Williams, M.D.

DEC 12 1946

VS 160

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 11 1946 at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1946 to Dec 11 1946 and that I last saw him alive on Dec 10 1946

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Cerebral traumas | |
| Due to Birth injury | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William S. Keller M. D.
Address Univ. Hosp. Date signed 12-11-46

X

G46136 B.C. 24041

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 64

Registered No. G46436

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) Don
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2301 Madison Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Leslie A. Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/12/46

8. AGE: Years | Months 1½ | Days 15 | If less than one day ____hr. ____min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 12 1946

18 (a) Funeral director
(b) Address Commissioner of Health

19 (a) DEC 12 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 27, 1946, at 10:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Status thymico-lymphaticus

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 11/27/46

VS 151

16137

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G16137

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1367- N. Stricker Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH DONNELLY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 54 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory University Medical School DEC 12 1946
Location

18 (a) Funeral director Commissioner of Health
(b) Address Huntington Williams, M.D.

19 (a) DEC 12 1946 (Date rec'd by Reg.) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3, 1946, at 8 a. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Lobar pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12-3-46

VS 151

G16138

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G16138 Registered No. 1084

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 min
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 422 S. Caroline st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Frank Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | | | hr. min. |

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 12 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 12 1946 (Date rec'd by Registrar) (b) Tunstall for Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-6- 1946, at 2 05 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Lobar pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 12-5-46

VS 131

C16139

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46E

Registered No. C16139

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2747 Washington Blvd
(c) Hospital or institution: Druid Park Conval Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 8
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4201 Sunnyside Av (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Clarence E Barber

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Eliza Barber
6 (c) If alive, give age 0 years

7. Birth date of deceased (mo., day, yr.) Jan 12 1863

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 11 | — | hr. min. |

9. Birthplace Wilkes Barre, Pa (Town, county, and state)
10. Usual Occupation
11. Industry or business —

FATHER 12. Name David Barber
FATHER 13. Birthplace Elmira Pa
MOTHER 14. Maiden Name Ruth Stalter
MOTHER 15. Birthplace New Jersey

16 (a) Informant Miss Barber
(b) Address 4201 Sunnyside Ave

17 (a) Burial Baltimore (Burial, cremation, or removal) (b) Date thereof 16 Dec. 46 (month) (day) (year)
(c) Cemetery or crematory Pottstad Cemetery
Location Pottstad - Pa

18 (a) Funeral director F. B. Wisheart & Son
(b) Address 700 Eutaw Place
DEC 12 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 12 1946 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Dec 12 1946 and that I last saw him alive on 7:00 A.M. Dec 12 1946.

Immediate cause of death: Carcinoma ascending colon — Duration 1 yr.
Due to:
Due to:
Other Conditions None
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: none

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton E Lawrence M. D.
Address 7443 Penta Heights Ave Date signed 12-12-46

X

G46440 G46440

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1936

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lexington St.
(c) Hospital or institution:
Home of Our Lady
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 937 McAleer Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary E. Belt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband Alfred H. Belt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8th 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 6 | 3 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name George Wisner
13. Birthplace York Pa.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Alfred H. Belt
(b) Address 937 McAleer Court

17 (a) Burial (b) Date thereof 12/14/46
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

DEC 13 1946

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 11th 1946, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1946, to Dec 11 1946 and that I last saw h[illegible] alive on Dec 11 1946.

| Immediate cause of death | Duration |
|---|---|
| (a) General Arteriosclerosis & Chronic Myocarditis | 5 yrs |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton F. Solomon
Address 127 S. Broad Date signed 12/14/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C16141 HEALTH DEPARTMENT—CITY OF BALTIMORE C16141

# CERTIFICATE OF DEATH 50

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4308 Mainfield St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 38 yrs. mos. da. How long in U. S. If of foreign birth? 42 yrs. mos. da.

2. FULL NAME Olive Ruth Kees 7-7-

If U.S. Veteran specify WAR No

(a) Residence: No. 4308 Mainfield Ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. Color or Race | 5. Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Married |

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ William George Kees

6. DATE OF BIRTH (month, day, year) Dec 28, 1894

| 7. AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 52 | 51 | 11 | 14 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Home

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Stevensville, Md.

MOTHER FATHER

13. NAME Edmund Bryan Palmer

14. BIRTHPLACE (city or town) (State or country) Queen Anne Co Md.

MOTHER

15. MAIDEN NAME Fannie E. Carmine

16. BIRTHPLACE (city or town) (State or country) Talbot County Md.

17. INFORMANT Husband - Wm G. Kees

(Address) 4308 Mainfield Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Woodland Park Date 12/16 19 46

19. UNDERTAKER Wm Cook Inc

(Address) 1217 St Paul St.

20. FILED 19

Registrar.

DEC 13 1946 Huntington Williams M.D.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) December 12 1946

22. I HEREBY CERTIFY, That I attended deceased from June 8, 1946 to Dec 12, 1946

I last saw her alive on Dec 12 1946 Death is said to have occurred on the date stated above, at 3.25 P. m.

The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Cancer of Breast | 1942 |
| Generalized Carcinomatosis | 9/46 |
| | |
| | |

Other contributory causes of importance:

Was an operation performed? Yes Date of 1943

For what disease or injury? Ca. of Breast

What test confirmed diagnosis? Biopsy Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Walter E. Kees M. D.

(Address) 4331 Hayford Rd.

G16142

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 947

Registered No. 810412

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3301 St. Paul Street
(c) Hospital or institution:
12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
2
(d) Street No. 3301 St. Paul Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Rebecca C. Fletcher

3 (b) If veteran, name war: No.
3 (c) Social Security Account No.: No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 22, 1871

8. AGE: Years 75 | Months 4 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace: Ohio
(Town, county, and state)

10. Usual Occupation: Nurse

11. Industry or business

FATHER
12. Name: William ?
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: Mrs. R. P. Volkmer
(b) Address: 8260 172nd St. Jamica, N. Y

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/13/46 (month) (day) (year)
(c) Cemetery Sewickley
Location: Sewickley, Pa.

18 (a) Funeral director: Wm. J. Tickner & Sons
(b) Address: North & Pa. Aves.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 13 1946 Huntingdon Pennsylvania

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12, 1946, at 4:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1930 to Present 19, and that I last saw her alive on Dec. 11, 1946.

| Immediate cause of death | Duration |
|---|---|
| Primary Pulmonary Embolism | |
| Due to Arteriosclerosis | |
| Due to | |
| Other Conditions None | |

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman B. Cole M. D.
Address 10 E. Biddle St., Date signed Dec. 12, 1946

X

Spec.—2-23-29—L. F. S.—500 Blks.

G46143

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

✓ 93D

G46143

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3712 Greenmount Ave. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Adaline (Mrs) Fairbank

(a) RESIDENCE NO. 3712 Greenmount Ave. ST., 12-1 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | White | Widow |

6a If married, widowed, or divorced HUSBAND of (or) WIFE of James G. Fairbank, Sr.

7 DATE OF BIRTH (month, day, and year) Mar. 10, 1871

| 8 AGE | Years | Months | Days | If LESS than 1 day, ...hrs. or ...min. |
|---|---|---|---|---|
| | 75 | 9 | 2 | |

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Edenburg
(State or country) Pennsylvania

10 NAME OF FATHER Amos Ripple

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Adaline Showers

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pennsylvania

14 Informant Mr. James G. Fairbank, Jr.
(Address) 3712 Greenmount Ave.

15 DEC 13 1946 [signature] Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 12 1946

17 I HEREBY CERTIFY, That I attended deceased from 1945, 19..., to Dec 12, 1946, that I last saw CR alive on Dec 12, 1946 and that death occurred, on the date stated above, at 11.05 Am.

The CAUSE OF DEATH* was as follows:

Hypertension - Cardiac Vascular disease

(duration) 1 yrs. + mos. ds.

CONTRIBUTORY (Secondary) Nephrosclerosis (duration) yrs. 1 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. V. D. Mark, M. D.

, 19 (Address) 513 E. 39th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Loudon Park Cem Balto. | 12/14 1946 |
| 20 UNDERTAKER | ADDRESS |
| Wm. J. Tickner & Sons, Inc. | North & Pa. Av |

G16144

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1930

Registered No. G16144

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4907 Edmondson ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28-4
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4907 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME — Belle Byrd

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| None | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Milton J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 6 | 4 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Smith
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary E. Starr
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Nellie L. Byrd
(b) Address 4907 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

DEC 12 1946

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 11, 1946, at 9:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to Dec 11 1946 and that I last saw h.. alive on Dec 11 1946.

| Immediate cause of death | Duration |
|---|---|
| Myocarditis | 1 yr. |
| Due to Arterio-Sclerotic Heart disease | 3 yrs. |
| Due to | |
| Other Conditions Arterio-Sclerotic gangrene of both lower Ext. | 3 mos. |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. P. Van Schuyver M. D.
Address 4618 Edmondson ave Date signed 12/12/46

G46145

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 126

Registered No. G46145

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4900 Crowson Ave
(c) Hospital or institution: 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70-3-18

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
11
(d) Street No. 4900 Crowson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** IDA R. MERRITT

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband ~~wife~~: Guy R. Merritt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 3 | 18 | hr. min. |

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George A. Albaugh
13. Birthplace Md.

MOTHER
14. Maiden Name Mary R. Linthicum
15. Birthplace Md.

16 (a) Informant Mr. G. Rogers Merritt
(b) Address 7103 Wardman Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 14, 1946 (month) (day) (year)
(c) Cemetery ~~Rockbottom~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa Aves. Balto. 17, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11, 1946, at 10:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1946 to Dec 11 1946 and that I last saw h~~er~~ alive on Dec 11 1946

| Immediate cause of death | Duration |
|---|---|
| Pulmonary embolism | 10 Min. |
| Due to Cholecystectomy | 3 weeks |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 11/20/46
Major findings of operation: gall stones
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold E. Grot M. D.
Address 8100 Harford Rd. Date signed 12/12/46

V S 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16146+07047

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 133A

G16146 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Fla. (b) County
(c) City or town Miami
(If outside city or town limits, write RURAL and give town)
(d) Street No. 737 N. E. 2nd Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sunlind Leavitt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1904

8. AGE: Years 42 | Months 9 | Days 4 | If less than one day: hr. min.

9. Birthplace New Hampshire Vermont (Town, county, and state)

10. Usual Occupation Dentist's Assistant

11. Industry or business

FATHER
12. Name Thos. Marshall
13. Birthplace New Hampshire

MOTHER
14. Maiden Name Margie Hartshorn
15. Birthplace New Hampshire

16 (a) Interment Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 12/15/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Maple Grove
Location West Orford New Hampshire

18 (a) Funeral director Wm. J. Eckner
(b) Address Meriden Conn.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 12 1946 at 12:52 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 10 1946 to Dec. 12 1946 and that I last saw he(r) alive on Dec. 12 1946

| | Duration |
|---|---|
| Immediate cause of death: Uremia | 1 mo. |
| Due to: Malignant Hypertension | 1 yr. |
| Due to: Pyelonephritis | |
| Other Conditions: Bronchopneumonia Arteriosclerosis generalized | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: Pyelonephritis Bronchopneumonia

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Andrew E. Salzano M.D.
Address Johns Hopkins Hosp. Date signed 12/12/46

VS 150

G46147

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

186a

Registered No. G46147

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 122 W. Lee st.
(c) Hospital or institution: (Doctor Franklin's Office) 22-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 719 S. Hanover st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Cynthia SOLOMON (

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1944

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 2 | 4 | 13 | hr. min. |

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name James Solomon
13. Birthplace Va

MOTHER
14. Maiden Name Mary M Lewis
15. Birthplace Va

16 (a) Informant Mary M Solomon
(b) Address 719 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Pk
Location Balto Co., Md

18 (a) Funeral director Daniel L Burns Jr
(b) Address 108 W Montgomery St

19 (a) (Date received by Registrar) (b) Registrar

DEC 13 1946 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 10th 19..., at 2 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/10/46 at 1:40 P. M.
(b) Where did injury occur? 719 S. Hanover st
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury fell down steps - 3rd floor

23. Signature H. J. Malden MD / A. G. Merrill M.D. Medical Examiner.
Date signed 12/11/46

X

G16148

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 166

Registered No. G16148

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette St
(c) Hospital or institution: Franklin Square
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3336 Virginia Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAX BERMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rose -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 52 | Months 8 | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (City, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name not known
13. Birthplace Russia

MOTHER
14. Maiden Name Eva
15. Birthplace Russia

16 (a) Informant Rose Berman
(b) Address 3336 Virginia ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location

18 (a) Funeral director Jack Lebos Inc
(b) Address 1729 E Baltimore St Huntington Williamsville, Md.

DEC 13 1946
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-11-1946 at 9P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet-wound of left chest and left lung, with hemorrhage into left chest.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Dec 11-1946 8 45 P. M.
(b) Where did injury occur? 910 Druid Hill Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Tavern While at work? Yes
(d) Means of injury Gunshot wound - Autopsy

23. Signature Lango G. Merrill M.D.
Medical Examiner.
Date signed 12/13/46

VS 191

G16149

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 115B

G16149 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2103 Bryant Ave.
(c) Hospital or institution: Baltimore Eye Ear Throat Charity Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 2D

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2103 Bryant Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jack Rashtein

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: ?

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21 1923

8. AGE: Years 23 | Months 5 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace ? Virginia (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business wholesale grocery business

FATHER
12. Name Frank W. Rashtein
13. Birthplace Russia

MOTHER
14. Maiden Name Lena Radin Rashtein
15. Birthplace Russia

16 (a) Informant Mother
(b) Address 2103 Bryant Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-46 (month) (day) (year)
(c) Cemetery or crematory Shaara Shalom
Location Windsor Mill Rd.

18 (a) Funeral director Jack Myers Inc
(b) Address 1139 E. Balto. St.

19 (a) ____ (Registered by registrar) (b) Huntington Williams

DEC 13 1946

VS 8

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12 1946, at 9:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 5 1946, to Dec. 12 1946, and that I last saw him alive on Dec. 12 1946.

Immediate cause of death: Pulmonary Embolism — Duration: Sudden

Due to: post-operative (tracheotomy)

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation Dec. 12 1946

Major findings of operation: Infected Tonsils

of autopsy: ?

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M L Braitstein M.D.

Address 1213 Eutaw Place Date signed 12/12/46

1

12/12/46

G46150 BARMER G46150

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 168

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2da
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 Saratoga st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Sydner Barmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Married |

6 (b) Name of husband or wife Willie Mae

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8 1909

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 37 | 1 | 3 | hr. min. |

9. Birthplace Mt Boykins, Virginia
(Town, county, and state)

10. Usual Occupation Presser

11. Industry or business

FATHER
12. Name William Barmer
13. Birthplace Jackson, N.C.

MOTHER
14. Maiden Name Rosa Janett
15. Birthplace Boykins, Va.

16 (a) Informant Rosa Barmer
(b) Address 313 N. Carey Street

17 (a) Burial (b) Date thereof Dec. 15, 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Zion Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 222 N. Bakers St.

19 (a) (b)
(Date rec'd by registrar)

VS 15) DEC 13 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9th 1946 at 3:45 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Dec death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull
Intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 18-2
(a) Date of injury 12/9/46 at 3:30 A M.
(b) Where did injury occur? 1004 Saratoga St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Pushed down steps.

23. Signature Howard J. Wellens M.D.
Medical Examiner.
Date signed 12/10/46

G16151

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93E

G16151 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2208 Chelsea Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-9
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2208 Chelsea Terrace (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME MARTHA KRATZ

3 (b) If veteran, name war ********** | 3 (c) Social Security Account No. *********

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Adam Kratz
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) August 12, 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 3 | 27 | ********** hr. ********** min. |

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name John Maurer
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant William Kratz
(b) Address 2208 Chelsea Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 13/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director F. B. Niblett & Son
(b) Address 1300 EUTAW PLACE

19 (a) DEC 13 1946 (Date filed by registrar) (b) Registrar

VS 180

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 1946, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 10 1946 to Dec. 9 1946 and that I last saw her alive on Dec. 9, 1946.

| | Duration |
|---|---|
| Immediate cause of death: Cerebral hemorrhage followed by paralysis | about 3 days |
| Due to: Advanced arterio-sclerosis | ? |
| Due to: | |
| Other Conditions: Myocarditis-about | 1 year |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. B. Niblett M. D.
Address 2220 Garrison Ave. Date signed

Huntington Williams, M.D.

Dr. Niblett. 93A 12/17/46

G46152

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1948

G46152 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 821 Hamilton Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** George Louis Beauchamp

3 (b) If veteran, name war: No.

3 (c) Social Security Account No. 214-18-0925

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26 1893

8. AGE: Years 53 | Months 5 | Days 15 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Liquor Store

FATHER 12. Name Harold O Beauchamp

13. Birthplace Md

MOTHER 14. Maiden Name Jane Bond

15. Birthplace Md

16 (a) Informant Miss Lorenz Beauchamp

(b) Address 2115 Guilford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 14-1946 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Balto Md

18 (a) Funeral director Stuart Gore

(b) Address 222 N Charles St

19 (a) DEC 13 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/11 1946, at 9:40 P M

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature C. J. Gulbinski M.D.
Medical Examiner.

Date signed 12/12/46

G46153

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83A

Registered No. G46153

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1029 N. Caroline st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1029 N. Caroline st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lydia Nugent
3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | widowed |

6 (b) Name of husband or wife James Nugent (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April - 19 - 1861

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 85 | 7 | 10 | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Johnson
13. Birthplace Maryland.

MOTHER
14. Maiden Name Lydia Johnson
15. Birthplace Maryland.

16 (a) Informant Lillie J Mason
(b) Address 1128 E. Lexington st
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Baltimore, Md.
18 (a) Funeral director Mac Dola Bailey
(b) Address 1421 E. Jefferson St.
19 (a) (b)
(Date rec'd by registrar) DEC 13 1946 Registrar

VS-150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** December - 10 1946, at 8:P. M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Oct 22 1946 to Dec 5 1946 and that I last saw her alive on Dec 5 1946

| Immediate cause of death | Duration |
|---|---|
| Cerebal Hemorrhage. | |
| Due to Arterio-sclerosis & Hypertension | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harris A. Pine M. D.
Address 118 Biquit St. Date signed 12/12/46

Huntington Williams M.D.

G16454

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 170 C

G16454 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp. 9-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2804 Parkwood Ave (If rural give location)
(e) Citizen of foreign country? Particulars (Yes or No)
If yes, name country

**3 (a) FULL NAME** Elias J. F. Zirckler ✓

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Grace
6 (c) If alive, give age 76 years
7. Birth date of deceased (mo., day, yr.) Oct 29 - 1859

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 87 | 1 | 10 | hr. min. |

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Henry Zirckler
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Bartman
15. Birthplace Germany Balto

16 (a) Informant Mrs Grace Zirckler
(b) Address 2804 Parkwood Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/46 (month) (day) (year)
(c) Cemetery or crematory Bald Cem
Location York Ave
18 (a) Funeral director J. Heuman & Son
(b) Address 3 r S Broadway
19 (a) DEC 13 1946 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-9th 1946, at 10 30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Intracranial & Intracerebral Hemorrhage,
Due to Lobar Pneumonia

Other Conditions Generalized Arteriosclerosis Advanced; Nephrosclerosis Fatty Cirrhosis of Liver
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/5/46 at 12 43 P. M. 9-2
(b) Where did injury occur? In front of 4202 Harford Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Pedestrian Struck by auto

23. Signature Homer J. Madeira M.D. Medical Examiner.
Date signed 12/10/46

G16155

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G16155 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 245 W. 31st. St.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 245 W. 31st. St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Oliver Rhodes

3 (b) If veteran, name war ----

3 (c) Social Security Account No. 217-12-9745

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Lillian M. Rhodes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11, 1883

8. AGE: Years 63 | Months 2 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name Oliver L. Rhodes
13. Birthplace Va.

MOTHER
14. Maiden Name Mollie Cochran
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Lillian M. Rhodes
(b) Address 245 W. 31st. St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-46 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director G. Howard Sterling
(b) Address 3207 W. North Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 13 1946 Huntington Williams

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12, 1946, at 8.50 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11th 1946 to Dec 12th 1946, and that I last saw him alive on Dec 12th 1946.

Immediate cause of death Coronary Thrombosis — Duration 2 hours

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Byrne
Address 710 Medical Arts Bldg Date signed 12-13-46 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6 TRANSCRIPTS

G46456 BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 194P

G46456 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1819 Rutland Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 Rutland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANKLIN H. GEES, JR.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife VIRGINIA MULLER,

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 29TH 1921

8. AGE: Years 25 | Months 8 | Days 17 | If less than one day hr. min.

9. Birthplace BALTO., MD. (Town, county, and state)

10. Usual Occupation APPRENTICE PRINTER

11. Industry or business

FATHER
12. Name FRANKLIN H. GEES, SR.
13. Birthplace BALTO, MD.

MOTHER
14. Maiden Name ELIZ. A. MURPHY
15. Birthplace BALTO.

16 (a) Informant MR. FRANKLIN GEES, SR.
(b) Address 2414 LOCH RAVEN RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-14-46 (month) (day) (year)
(c) Cemetery or crematory PARKWOOD CEM.
Location CITY

18 (a) Funeral director J. LISTON WIEDEFELD
(b) Address 501 E. 22ND ST.

19 (a) Date received DEC 13 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10th 1946, at 9.45P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D. Medical Examiner.
Date signed 12-11-46

VS 181

G46157

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 1947

G46157
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 411 S. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George STUMPTNER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 21 1876

8. AGE: Years 70 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace Hanford Co. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Jacob Stumpner
13. Birthplace Germany

MOTHER 14. Maiden Name Catherine Barkley
15. Birthplace Germany

16 (a) Informant Mary Kirkstner
(b) Address 20 South Elwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/46. (month) (day) (year)
(c) Cemetery or crematory St. Mathias
Location O'Donnell Street

18 (a) Funeral director C. Schimunek
(b) Address 2601 E. Madison St.

19 (a) (b) Registrar

DEC 13 1946

VS 191

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 1946, at 11:15 M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. (Medical Examiner)
Date signed 12/12/46

G46158

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13 B

Registered No. G46158

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 927 Morris Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Freeman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife Lewis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1912

8. AGE: Years 34 | Months 4 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Louis Freeman
13. Birthplace Unknown

MOTHER
14. Maiden Name Estelle Robertson
15. Birthplace Virginia

16 (a) Informant John Addison
(b) Address 927 Morris St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 19 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location

18 (a) Funeral director C. Hasley
(b) Address 927 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Registrar

Dec 13 1946 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13 1946, at 3 40 A. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George E. Merrill M.D. Medical Examiner.
Date signed 12/13/46

JL - 1564 G16159

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1869

Registered No. G16159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 - 6 - 8 28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2309 Tucker Ave. (2309 3)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles J. Carroll

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1858

8. AGE: Years 88 | Months 4 | Days 0 | If less than one day ____ hr. ____ min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Carroll
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Ireland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director J. H. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) Date rec'd by reg. DEC 13 1946 Huntington Williams, M.D. Registrar

VS-150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1946, at 6.40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1935, to Dec. 10 1946, and that I last saw h. alive on Dec. 10 1946.

| Immediate cause of death | Duration |
|---|---|
| Arteriosclerotic cardiovascular disease (congestive) | 3 days) |
| Due to Bronchiectasis | ? yrs |
| Due to Fracture, neck of left femur | 2 days |
| Other Conditions Hydronephrosis | ? |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: 0

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 26-17
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 12-4-46 at M
(c) Where did injury occur? Balto. City Hospital
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital While at work? No
(Specify type of place)
(e) Means of injury Slipped & fell - fell.

23. Signature Thomas J. Todd M. D.
Address Balto. City Hosps Date signed 12-11-46

To be approved by Medical Examiner George H. Merrill M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46160

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94A

Registered No. G46160

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2430 Frederick Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County A.A.Co.
(c) City or town Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ritchie Highway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ALICE ELVATON ARVEY

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| - | - |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Anthony Arvey
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) March 26, 1893

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | 8 | 16 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Charles Brown
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Haley
15. Birthplace Maryland

16 (a) Informant Mrs Elizabeth Gorsuch
(b) Address 1719 McKean Ave.

17 (a) Burial (b) Date thereof 12/16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Ritchie Highway

18 (a) Funeral director John F. Denny, Inc.
(b) Address 715 Light St.

19 (a) DEC 13 19 (b)
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/12/46 19 at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-12 1946 to 12-13 1946 and that I last saw her alive on 12-12 1946

Immediate cause of death Coronary occlusion — Duration 1½ hrs.
Due to
Due to
Other Conditions Obesity
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Vernon Williamson M. D.
Address 201 Hilltop Ave. Date signed 12-13-46

Huntington Williams, M.D. Coroner, Md.
Mary A. Merrill MD,

VS 150

G46161

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 448

Registered No. G46161

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnets Ave.
(c) ~~Hospital or~~ institution:
Pine Ridge Convv. Home.
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 14
(e) Length of stay in Baltimore (~~yrs., mos., or~~ days) 14

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna (b) County York.
(c) City or town Shrewsbury, Penna.
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? ... years

3 (a) FULL NAME Dora M. Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John B. Maguire

6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) May 26, 1880

8. AGE: Years: 66 | Months: 6 | Days: 17 | If less than one day: ... hr. ... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Adam S. Bailey
13. Birthplace Baltimore Co. Md.

MOTHER
14. Maiden Name Annie Jones
15. Birthplace Baltimore Co. Md.

16 (a) Informant Clifford Benson
(b) Address Shrewsbury, Penna

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 16, 1946 (month) (day) (year)
(c) Cemetery or crematory Wiseburg Cemetery
Location Parkton, Md. R.D. 1

18 (a) Funeral director Jacob Hartsplain
(b) Address West Freedom, Pa.

19 (a) ... (Date received by Registrar) (b) Huntington Mills M.D.

DEC 19 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-13-1946 1946, at 9:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 4 1945, to 12-13 1946, and that I last saw her alive on 12-13 1945.

| Immediate cause of death | Duration |
|---|---|
| Adeno Carcinoma | 2 yrs. |
| Due to | |
| Due to | |
| Other Conditions | Over |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. E. Cole M. D.
Address 1014 York Road Date signed 12-13-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46462

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13 A

G46462 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 Wolf St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Collins Willis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1903

8. AGE: Years 43 | Months | Days | If less than one day hr. min.

9. Birthplace N. Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Davidson Chemical Co.

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Bambee Hutchinson
(b) Address 1009 N. Wolfe St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/13/46 (month) (day) (year)
(c) Cemetery or crematory Lake City N. C.
Location N. C.

18 (a) Funeral director Mrs. Ruth A. Chester Douglass
(b) Address 1129 N. Carrollton St.

19 (a) DEC 13 1946 (Date received by registrar) (b) Huntington Williams, M.D.

VS 191

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-9 1946, at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary - arteriosclerosis Renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mendelsohn M.D. Medical Examiner
Date signed 12-9-46

G46163

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 M

G46163 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and entered. Be sure that the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 823 N. Bond St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 823 N. Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lilly Garnett

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Colored | Widow |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 4 | 8 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Rev. Simina Williamson
(b) Address 1222 N. Caroline St

17 (a) Burial (b) Date thereof Dec 13 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Arbutus Md.

18 (a) Funeral director Md. Funeral Co. Elliott & Dyer
(b) Address 1209 N. Caroline St.

19 (a) DEC 13 1946 (b) Burlington Wilson Registrar
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 10 1946, at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-14 1946 to 12-10 1946 and that I last saw h[illegible] alive on 12-6 1946

Immediate cause of death — Duration

Carcinoma - gastric — 9 mos.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Raynor Browne M.D.
Address 1101 E. Madison St Date signed 12/11/46

VS 150

G46164

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46164 Registered No.

506013

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 Fleet St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Kerp (KLUCZYK)

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-1426

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-2-1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | | | hr. min. |

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?. Brush
13. Birthplace Poland

MOTHER
14. Maiden Name ? ? ?
15. Birthplace ?

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 12-14-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore Md.

18 (a) Funeral director George A. Weber
(b) Address 705 S Ann st

19 (a) (b) Huntington Williams, Registrar
(City or town) (b) (Registrar)
DEC 19 1946

VS 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Dec. 12 1946 at 3.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 5 1946 to Dec. 12 1946 and that I last saw her alive on Dec. 12 1946.

Immediate cause of death Pneumonia

Due to Etiology undet

Due to

Other conditions Leukemia Arterios clerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Part I: Sole

Part II:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Douglas Carroll
Address JHH Date signed 12 Dec 1946

109

G46465

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1628

G46465 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered, or the certificate will be returned for correction. Use additional sheet if necessary. Be sure to state the causes of death clearly and legibly. Underlining is especially important. Physicians: please write the cause of death in the space provided.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 309 Maydell Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25

(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 Maydell Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Maggie Glatzel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband August V. Glatzel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15th 1863

8. AGE: Years: 83 | Months: 2 | Days: 27 | If less than one day: hr. min.

9. Birthplace Balto. Co. Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name Joseph Kahlor
13. Birthplace Unknown

MOTHER
14. Maiden Name Rose
15. Birthplace "

16 (a) Informant Lydia Johnson
(b) Address 309 Maydell Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) 12 13 1946 (Date rec'd by Registrar) (b) Clayton Williams Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 12th 1946, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to Dec 8 1946 and that I last saw him alive on Dec 8 1946.

Immediate cause of death: Senility

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis T. Levy M. D.

Address 1924 W. Lafayette Ave Date signed 12/13/46

VS 150

G16166 G16166

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1312 Windermere Ave
(c) Hospital or institution: 9-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 Windermere Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3-(a) FULL NAME Florence Annetta Goertz

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced: |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband Joseph A. Goertz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15th 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 1 | 27 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name William Rector
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ann Marie Bratt
15. Birthplace England

16 (a) Informant Walter H. Goertz
(b) Address 1312 Windermere Ave

17 (a) Burial (b) Date thereof 12/16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 18 1946

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 12th 1946; at 4:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1946, to 12 Dec 1946, and that I last saw h[illegible] alive on 12 Dec 1946.

Immediate cause of death: Asthenia — Duration: 3 months

Due to: Carcinoma of breast (left) with

Due to: Metastasis

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation June 1944

Major findings of operation: Carcinoma of breast left

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hugh C. Taylor M.D.
Address 3902 Greenmount Ave Date signed 13 Dec '46

Examined by me Hunter Jones Registrar
Date Dec 18 1946

G46167

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1920

G46167 Registered No.

1. PLACE OF DEATH: 12 N. Monroe St.
(a) Baltimore City, Maryland
(b) Street address 12 N. Monroe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 N. Monroe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilhelmina (Minnie Schmidt.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Wm. C. Schmidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 2 | 1 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name August Hucksoll
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Annie Haesloop
15. Birthplace Germany

16 (a) Informant Anna Persch
(b) Address 12 N. Monroe St.

17 (a) Burial (b) Date thereof 12/15/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.
(a) Funeral director George Weber & Son
(b) Address 2503 Edmondson Ave.
(a) (b)
Date of this registrar's signature [illegible] Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11, 1946, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946, to Dec. 11 1946, and that I last saw he alive on Dec. 11 1946.

| Immediate cause of death | Duration |
|---|---|
| Pneumonia - Bronchial | 10 days |
| Due to Tuberculosis Laryngeal | ? |
| Due to Hydronephrosis - Bilat. | ? |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Samuel C. Boyer M. D.
Address 1605 E. Balto. Date signed 12/13/46

VS 150

B.C.H.-64903
G16468

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

60 C

Registered No. G16468

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Caroline & Huffman
(c) Hospital or institution: St. Joseph's Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) "

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1439 Stonewood Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Ford (Michael Joseph Ford)

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 12th., 1946

8. AGE: Years #, Months #, Days #, If less than one day 7 hr. 40 min.

9. Birthplace Balt. Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Daniel A. Ford Jr.
13. Birthplace Baltimore County

MOTHER
14. Maiden Name Margaret Oberle
15. Birthplace Baltimore, Md.

16 (a) Informant Daniel A. Ford Jr.
(b) Address 1439 Stonewood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/46 (month) (day) (year)
(c) Cemetery or crematory Our Cathedral
Location Edmondson Ave.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) DEC 13 1946 (Date rec'd by Registrar) (b) Huntington Willis Registrar M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12 1946, at 9:25PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1946, to Dec 12 1946, and that I last saw him alive on Dec 12 1946.

| Immediate cause of death | Duration |
|---|---|
| Cardio. resp. failure | |
| Due to Atelectasis | |
| Due to Premature separation of placenta | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard A. Young M. D.
Address St. Joseph's Hosp. Date signed 12/12/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Enter the causes of death clearly and legibly. Underline the cause to which death should be charged statistically. Physicians: please write the correct age is especially important.

G46169

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46169 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4013 Liberty Heights Ave.
(c) Hospital or institution: Alberta Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County 6666
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5511 Fernpark Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME S. Hamilton Carter

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Katherine Carter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March, 13th 1874

8. AGE: Years 74 Months 8 Days 28 If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Retired Credit Mgr.
11. Industry or business Hecht Bros.

FATHER
12. Name Stacie Carter
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Miles
15. Birthplace Virginia

16 (a) Informant Mrs. William Carter
(b) Address 5311 Fernpark Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 14 1946 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Balto. Co. Md.

18 (a) Funeral director Miller & Lawrence
(b) Address 4010 Liberty Heights Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 18 1946
Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 11th. 1946, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2/45 19 to 12/11/46 19, and that I last saw h. alive on 12/11/46 19.

Immediate cause of death: Heart Failure — Duration: 1 Day
Due to: Pneumonia Congestive — 2 Days
Due to: Cerebral Hemorrhage — 3 Days
Other Conditions: Senility
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Boulton
Address 890 N. Gerson Blvd Date signed Dec 14

G16170

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

463

G16170 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4029 Cranston Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4029 Cranston Ave
(If rural give location)
(e) Citizen of foreign country? NO
If yes, name country

3 (a) FULL NAME Anna Elizabeth Richards

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband ~~or wife~~: Edward Richards

6 (c) If alive, give age ~~years~~

7. Birth date of deceased (mo., day, yr.) Nov 3rd (1882)

8. AGE: Years 64 (65) | Months 1 | Days 9 dys | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation none.

11. Industry or business

FATHER
12. Name Michael J. Ward
13. Birthplace Ireland.

MOTHER
14. Maiden Name Mary C. Eagan
15. Birthplace Baltimore, Md

16 (a) Informant Hugh Ward,
(b) Address 1318 N. Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/46 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Kuck
(b) Address 5305 Harford Road

19 (a) [illegible] (b) [illegible]
(Date and City registered) Registrar M.D.

VS 200

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 12-1946, at 10:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15- 1938 to 12-12-1946, and that I last saw h[illegible] alive on 12-11-1946.

| Immediate cause of death | Duration |
|---|---|
| (a) Organic Heart Disease | |
| Due to | |
| Due to | |
| Other Conditions Carcinoma of Stomach, Hypertension | about 7 mos |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chester Riland, M. D.
Address 2532 Edmondson Ave Date signed 12-12-46

Huntington

95C

Dr. White
532 E. 22nd St.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

50

G46171
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to state the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution:
Saint Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 Montpelier Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Alice D. Long

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | married |

6 (b) Name of husband or wife Ernest B. Long
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 9 | 26 | hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Preston P. Keenan
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah E. Hudson
15. Birthplace Md.

16 (a) Informant Mrs. Ernest B. Long
(b) Address 1627 Montpelier Street

17 (a) Burial (b) Date thereof 12/16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pakwood Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) DEC 13 1946 (b) Huntington, Maryland
(Date rec'd by Registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 12th, 1946 at 2-A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10/1946, to 12/11/1946, and that I last saw h[illegible] alive on 12/11/1946.

| Immediate cause of death | Duration |
|---|---|
| Carcinomatosis Hemorrhage | 12 hours |
| Due to Prolonged Carcinomatosis (Metastatic) | 2 mos. |
| Due to Primary Carcinoma of Ovaries | 1 year |
| Other Conditions Hysterectomy | 1 year |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. Mick M. D.
Address 532 E 22nd St. Date signed 12/13/46

VS 150

646172

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13B

Registered No. 646172

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 702 Greenmount (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Josephine Cooper

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James D. Cooper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years: 71 | Months | Days | If less than one day: hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name William Walker
13. Birthplace Va

MOTHER
14. Maiden Name Mary Stribling
15. Birthplace Va

16 (a) Informant William Walker
(b) Address 703 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md

18 (a) Funeral director Mrs. Fannie A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams

VS 19 DEC 13 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1946, at 11:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pulmonary Tuberculosis
Rheumatic Endocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mason M.D.
Medical Examiner.
Date signed 12-10-46

X

G46173

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

Registered No. G46173

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1434 Ward Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimoore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1434 Ward Stree6
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** SADIE A TURNER

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Agrippa Turner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30, 1901

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 45 | 7 | 11 | hr. min. |

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name Frank Smith
13. Birthplace Va.
14. Maiden Name Fanny Smith
15. Birthplace Va.

16 (a) Informant Mrs. Estella Lee
(b) Address 1112 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-16-46 (month) (day) (year)
(c) Cemetery or crematory National Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH Dec. 11 1946, at 3:35 M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/1 1946 to 12/11 1946, and that I last saw h[illegible] alive on 12/10 1946.

| Immediate cause of death | Duration |
|---|---|
| Carcinomatosis Breast metastases | 6 Mos. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 600 Mariner Bldg Date signed 12/12

VS 150

DEC 13 1946

Huntington Williams, M.D.

G16174

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 56B

G16174 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1813 Etting Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 3

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 Etting Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** REVA HINTER

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | Widow |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 3 | 23 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Petus Burris
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Williams
15. Birthplace Md.

16 (a) Informant Mr. George F. Burris
(b) Address 1813 Etting St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 11 1946, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2-1946 to 12-11-1946 and that I last saw him alive on 12-7-1946

Immediate cause of death: Chronic myocarditis — Duration

Due to

Due to

Other Conditions Fibroid Tumor
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. R. Campbell M. D.
Address 718 Dolphin St. Date signed 12-12-46

VS 150

93D

G46475

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1317

G46175 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2027 N. Payson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2027 N. Payson St.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Matthew Haensler

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 216-07-6049

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Emma Haensler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1876

8. AGE: Years 70 | Months 10 | Days 1 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Food Fair

FATHER
12. Name Matthew Haensler
13. Birthplace Germany

MOTHER
14. Maiden Name ? Essenwein
15. Birthplace Germany

16 (a) Informant Mrs. Chas. J. Heller
(b) Address 3931 Kimble Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Baltimore

18 (a) Funeral director Geo. W. Little
(b) Address 2700 Edmondson Ave.

19 (a) (Date received by registrar) DEC 13 1946 (b) Huntington Williams
VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12, 1946, at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1946, to Dec 12 1946, and that I last saw [redacted] alive on Dec 11 1946.

Immediate cause of death: Coronary Thrombosis — Duration 12/12/46
Chronic nephritis & carcinoma (Kidney) —
Due to Cardio-vascular-renal disease — —
Due to Arterio-sclerosis — —
Other Conditions Chronic nephritis secondary to cardiac lesion —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —
23. Signature Louis F. Haensler M. D.
Address 722 N. Kenwood Ave. Date signed 12/13/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined before it is written. Physicians: please write the causes of death clearly and legibly. Information is especially important.

G16476

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G16476 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp. 19-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days) 33 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1725 McHenry St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME John H. BLANTZ

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 705-10-8243

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Florence Blantz

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) June 11, 1885

8. AGE: Years 61 | Months 6 | Days 1 | If less than one day ____hr. ____min.

9. Birthplace Racine Wisconsin (Town, county, and state)

10. Usual Occupation Brakeman

11. Industry or business Western Md. R. R.

FATHER
12. Name John H. Blantz
13. Birthplace Germany

MOTHER
14. Maiden Name Ernestine Schatz
15. Birthplace Germany

16 (a) Informant Mrs. Florence Blantz
(b) Address 1725 McHenry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Bluff
Location Annopolis, Md.

18 (a) Funeral director Geo. W. Little
(b) Address 2700 Edmondson Ave.

19 (a) (Date rec'd by Registrar) DEC 13 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12, 1946, at 5:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? ____ While at work? ____
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 12/13/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 181

G16177 G16177

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 47C

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland Mercy Hosp.
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30d.
(e) Length of stay in Baltimore (yrs., mos., or days) 18 Mos.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Michigan (b) County
(c) City or town Detroit
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~
(If rural give location)
(e) Citizen of foreign country? ~~ (Yes or No)
If yes, name country ~~

3 (a) FULL NAME Fred A. Nolan (Fred -- not Frederick)

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife Mary E. Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 30, 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 3 | 17 | hr. min. |

9. Birthplace Michigan (Town, county, and state)
10. Usual Occupation Insp. of Balto. Transit Co.
11. Industry or business

FATHER
12. Name Patrick Nolan
13. Birthplace Michigan

MOTHER
14. Maiden Name Eliz. Hammans
15. Birthplace Michigan

16 (a) Informant Mrs F. Nolan
(b) Address 3700 N. Chas. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Sepulcher
Location Detroit, Michigan

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) (Date rec'd by local reg.) (b) Registrar

DEC 13 1946 Huntington, Md.

VS 199

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12 1946 at 6 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 13, 1946, to Dec 12 1946 and that I last saw h. alive on Dec 12 1946

| Immediate cause of death | Duration |
|---|---|
| 3 Respiratory Failure | |
| Due to Bronchogenic Carcinoma | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James V. Minor Jr. M. D.
Address Mercy Hospital Date signed 12/17/46

X

G16478

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

CWK-106559

G16478 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1429 Mosander Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vera B. McLaughlin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Roy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 5-1906

8. AGE: Years 40 | Months 3 | Days 7 | If less than one day hr. min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Webster Cross
13. Birthplace West Virginia

MOTHER
14. Maiden Name May Lewis
15. Birthplace West Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec. 13, 1946 (month) (day) (year)

(c) Cemetery or crematory
Location Cave Hill Cemetery

18 (a) Funeral director Roland L. Fisher
(b) Address 2112 Dundalk Ave.

19 (a) (Date rec'd by registrar) (b) Huntington, W. Va. (Registrar)

DEC 13 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 1946 at 5:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 2 1946 to Dec. 12 1946, and that I last saw h er alive on Dec. 12 1946.

Immediate cause of death: Heart Failure — Duration:

Due to: Hypertensive Heart Disease — Duration: 6 yrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.
Address Balt. City Date signed 12/13/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16479

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 9HR

G16479 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5d
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 Low st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Earley Meadows

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-16-3666

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 12/10 1946, at 11 25 P.M

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | married |

6 (b) Name of husband or wife Ida Meadows
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | | | hr. min. |

9. Birthplace hc (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Ned Meadows
13. Birthplace hc

MOTHER
14. Maiden Name Alice Bullocks
15. Birthplace hc

16 (a) Informant Annie B. Newton
(b) Address 1016 Low St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 14-1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A. A. Co. Md.

18 (a) Funeral director Robert L Williams
(b) Address 1525 McCulloh St Huntington Woods, Md.

19 DEC 13 1946 (Date rec'd by registrar) (b) Registrar

21. I certify that I took charge of the remains described above, held an Autopsy on Dec 13 1946 thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary artery Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L Merrill M.D. Medical Examiner.
Date signed 12/11/46

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly

G16180 / 504673

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131A

G16180 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 605 S. Bradford St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Anna Yengen.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Roy Yengen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-29-09.

8. AGE: Years 37 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Waitress - seamstress

11. Industry or business

FATHER 12. Name Ernest Nelson

13. Birthplace Md.

MOTHER 14. Maiden Name Emma Dreager.

15. Birthplace Md

16 (a) Informant Friend

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 17 1946 (month) (day) (year)

(c) Cemetery or crematory Mt Rose

Location York Rd

18 (a) Funeral director [illegible]

(b) Address [illegible]

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 DEC 13 1946 Huntington Williams, M.D.

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH Dec. 13 1946, at 12.01 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1946, to Dec. 13 1946, and that I last saw her alive on Dec. 13 1946.

| Immediate cause of death | Duration |
|---|---|
| Acidosis and Cardiac failure | |
| Due to Uremia and arterial hypertension | |
| Due to Chr. glomerulo-nephritis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Granular contracted kidneys.

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E. Mason M. D.

Address Johns Hopkins Hosp. Date signed 13 Dec 46

G16181

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1796

Registered No. G16181

write the causes of death clearly and legibly. Physicians: please write

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County.....
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3438 University Place
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country No

**3 (a) FULL NAME** DR. WARDER A. HALL

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| MALE | WHITE | MARRIED. |

6 (b) Name of husband or wife Caroline
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-21-1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | 4 | 21 | ....hr. ....min. |

9. Birthplace Clarksburg W Va
(Town, county, and state)
10. Usual Occupation DENTIST
11. Industry or business

FATHER
12. Name Dr. A. B. Hall
13. Birthplace Penna

MOTHER
14. Maiden Name Myra Pritchard
15. Birthplace Clarksburg W Va

16 (a) Informant Morris P. Hall
(b) Address Clarksburg, W Va

17 (a) REMOVAL (b) Date thereof DEC. 13, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MASONIC CEM.
Location CLARKSBURG, W. VA.

18 (a) Funeral director WILLIAM COOK, INC.
(b) Address 1217 ST. PAUL ST.

19 DEC 13 1946 (Signature) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** DECEMBER 12, 1946, at 6:15 P.M.

**21.** I certify that I took charge of the remains described above, held an AUTOPSY thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Barbiturate poisoning (Pentothal)

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at 4/1 M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? P.P. While at work?.....
(d) Means of injury.....

23. Signature George G. Morrill M.D.
Medical Examiner.
Date signed 12/13/46

VS 191

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1936

Registered No. G46182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 712 S. Brunswick St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 217 S. Bentalou St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

**3 (a) FULL NAME** Alice May Hartman

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Charles Hartman
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 1, 1859
8. AGE: Years 87 | Months 5 | Days 11 | If less than one day hr. min.
9. Birthplace Richmond Virginia (Town, county, and State)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Unknown
13. Birthplace Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace Virginia

16 (a) Informant Theodore Hartman
(b) Address 217 S. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-16-46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md.

18 (a) Funeral director George L. Schroeder
(b) Address 2101 Frederick Ave.

DEC 14 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 12, 1946, at 9:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 26 1946 to Dec 12 1946, and that I last saw h[illegible] alive on Dec 11 1946.

Immediate cause of death: Hypertensive Heart Disease — Duration: 6 mos.
Due to
Due to
Other Conditions Uremia — 4 days
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alberta Hartman
Address 2030 W. Lexington Ave. M. D. Date signed 12/12/46

VS 150

G46183

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 93D

Registered No. G46183

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1600 Jackson St
(c) Hospital or institution: ~

24-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County ******
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1600 Jackson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ROBERT BERGMAN

3 (b) If veteran, name war -
3 (c) Social Security Account No. -

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Ellen O'Brian
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) March 7, 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 9 | 5 | hr. min. |

9. Birthplace W.Va. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. R.W. Bergman
(b) Address 1600 Jackson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director John F. Denny Inc.
(b) Address 715 Light St.

19 DEC 14 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION** p

20. DATE OF DEATH 12/12/46 19 at 6:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1 1946 to 12-12 1946, and that I last saw him alive on 12-11 1946.

| | Duration |
|---|---|
| Immediate cause of death Chronic Myocardial degeneration | 5yr. |
| Due to Arteriosclerosis | 5yr. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A.J. Lolland M. D.
Address 707 E. Fort Ave. Date signed 12-14-46

VS 150

X

G16184

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

Registered No. G16184

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 815 S. Ann st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 815 S. Ann ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME RAYMOND H. ROBERTS

3 (b) If veteran, name war Spanish-American | 3 (c) Social Security Account No.

4. Sex m | 5. Color or race w | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband or~~ wife Nora C. Roberts

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6th 1879

8. AGE: Years 69 | Months 11 | Days 6 | If less than one day hr. min.

9. Birthplace Pittsburgh Pa. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Machinist

FATHER 12. Name Robert A. Roberts

13. Birthplace Pa.

MOTHER 14. Maiden Name Anna L. Fingle

15. Birthplace Pa.

16 (a) Informant Nora C. Roberts

(b) Address 815 S. Ann St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/16/46 (month) (day) (year)

(c) Cemetery ~~or crematory~~ U. S. National

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St Paul St.

19 (a) DEC 14 1946 (Date rec'd by registrar) (b) Hunter Williams Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/12/46 19 , at 10:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertonic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner.

Date signed 12/13/46

PRINT WRITE LEGIBLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16185

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

G16185 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1404 W Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1404 W Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Dorothea Lampert

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| NC | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband Henry Lampert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28 1864

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 85 | 8 | 15 | hr. min. |

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Louis Vogt
13. Birthplace

MOTHER
14. Maiden Name Mary Peters
15. Birthplace

16 (a) Informant Mrs Lottie Read Supt
(b) Address 1404 W Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 129 S Paca St

19 DEC 14 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 12 1946, at 9:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/16 1929 to 12/12/ 1946, and that I last saw her alive on 12/11/ 1946

Immediate cause of death: Myocarditis, chronic of arterio-sclerotic origin — Duration: 3 wks.
Due to
Due to
Other Conditions Generalized arterio-sclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Edward B Darrell
Address 11 E. Chase St., Balto 2 Date signed 12/13/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46186

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1317

G46186 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 720 W. North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 720 W. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Edith C. Watts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 23rd 1880

8. AGE: Years 66 | Months 8 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md. (town, county, and state)

10. Usual Occupation Clerk

11. Industry or business U.S. Custom House

FATHER
12. Name Nathaniel Watts
13. Birthplace Md.

MOTHER
14. Maiden Name Amelia Boyle
15. Birthplace D.C.

16 (a) Informant Jeanette Earle
(b) Address 5803 Halwyn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Jac
(b) Address 2317 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar's signature

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 11th 1946, at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 20 1946, to Dec. 11 1946, and that I last saw h.e.r alive on Dec. 11 1946.

| | Duration |
|---|---|
| Immediate cause of death: Chr. Interstitial Nephritis | Oct. 20, 46 |
| Due to Arterio-sclerosis | 5 yrs. |
| Due to Myocard. Fib | 5 yrs |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Earl H. Benson, M.D.
M. D.
Address 5111 York Rd Date Dec 13, 1946

DEC 14 1946

VS 150

G46187

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1930

Registered No. G46187

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied if correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 218 Ridgewood Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Washington Apts Eutaw St (If rural, give R.F.D. number)
(e) Citizen of foreign country? Not Foreign Born (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles Morris Howard

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Harriet Wade Spence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 31 1864

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | 8 | 13 | hr. min. |

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business

FATHER
12. Name Frank Key Howard
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Lydia Morris
15. Birthplace Balto Md

16 (a) Informant Mrs A. C. de Roth
(b) Address 116 Charles St Boston Mass

17 (a) Cremation (b) Date thereof Dec 14 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry W. Jenkins & Son
(b) Address McCulloh & Orchard Sts

19 (a) DEC 14 1946 (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 12/13 1946, at 7:15 A.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from Aug 1945 to Dec 13 1946, and that I last saw h[illegible] alive on Dec 3 1946.

Immediate cause of death: Myocarditis Arterio-Sclerosis — Duration: Gradual

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

**23.** Signature W. H. Crosby M. D.
Address 1403 Park Ave Date signed 12/13/46

VS 150

G16188

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 93E

G16188 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3209 N. Charles St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 ✓
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore ✓
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3209 N. Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Thomas L Shearer

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | white | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Feb 13 1869

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 87 | 10 | 0 | hr. min. |

9. Birthplace Reading Pa.
(Town, county, and state)

10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name Thomas Shearer
13. Birthplace Scotland

MOTHER
14. Maiden Name Harriet L. Fox
15. Birthplace Pa.

16 (a) Informant Mary Butler Shearer
(b) Address 3209 N. Charles St

17 (a) Burial (b) Date thereof Dec 16 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Henry W. Jenkins Sons
(b) Address McCulloh & Orchard Sts

19 DEC 14 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1946 at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1946 to Dec 13 1946, and that I last saw h[illegible] alive on Dec 13 1946

| Immediate cause of death | Duration |
|---|---|
| Myocarditis | |
| Due to Age | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: No
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John M Finney M. D.
Address 612 Cathedral Date signed

VS 150

G16189

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 193E

Registered No. G16189

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1209 Smithson St
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 Smithson St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Ollie Rich

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Frank

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5-5-1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 7 | 8 | hr. — min. — |

9. Birthplace Richmond County Va (Town, county and state)

10. Usual Occupation Laundress

11. Industry or business —

FATHER
12. Name Warren Thompson
13. Birthplace Va

MOTHER
14. Maiden Name unknown
15. Birthplace —

16 (a) Informant Pearl Rich
(b) Address 1209 Smithson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-46 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania ave

19 (d) DEC 14 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-13 1946, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-2 1946, to 12-13 1946, and that I last saw her alive on 12-12 1946

| Immediate cause of death | Duration |
|---|---|
| Myocarditis | over 6 Mos |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Frank J. Saunders M. D.
Address 1029 N. Stricker St. Date signed 12-13-46

X

G16190

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1318

G16190 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Eutaw & Wilkens Aves
(c) Hospital or institution: St Agnes Hosp 15-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 401 Fernhill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George A Pitmore, Jr

3 (b) If veteran, name war No | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Wh | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Minnie Miller | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 14 - 1877

8. AGE: Years 69 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Rocky Ridge Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name George A Pitmore, Sr
13. Birthplace Md

MOTHER 14. Maiden Name Mary Newcomer
15. Birthplace Md

16 (a) Informant E. F. Waddle
(b) Address 401 Fernhill Ave Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 16-46 (month) (day) (year)

(c) Cemetery or crematory Vaughs Cem
Location Mt Lebanon Md

18 (a) Funeral director M L Edgett Son
(b) Address Thurmont Md

19 DEC 14 1946 (Date rec'd by registrar) Huntington Willis Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/13 1946, at 9:14 M

21. I certify that death occurred on the date above stated, that I attended deceased from 12/2 1946 to 12/13 1946 and that I last saw h[illegible] alive on 12/13 1946

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure | |
| Hypertension and CVD - Age | Cardiac |
| Due to Chronic nephritis | hydronephrosis |
| + 13 yr. | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D W Mentz
Address St Agnes Date signed 12/13/46 (M) (D)

VS 150

246191 — 2nd

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 246191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2424 Mt Hope St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mary M. Cleveland

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mr. Allen Cleveland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 14, 1873

8. AGE: Years 73 | Months 3 | Days 28 | If less than one day ....hr. ....min.

9. Birthplace Norfolk Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Housework

FATHER
12. Name John Peckard
13. Birthplace Virginia

MOTHER
14. Maiden Name Elizabeth Stubbs
15. Birthplace Virginia

16 (a) Informant Dayton Whitelock Bernard.
(b) Address 32 3/4 Patterson Pk. Ave. Balto. Md.

17 (a) Burial (b) Date thereof 12/14/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Druid Ridge
Location Pikesville Md. Balto.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa Aves. Balto. 17, Md.

19 DEC 14 1946 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12, 1946, at 9¼ A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1946, to Dec 12 1946, and that I last saw h[er] alive on Dec 11 1946

| | Duration |
|---|---|
| Immediate cause of death Terminal bronchopneumonia | 6 days |
| Due to Atelectasis. | 4 days |
| Due to Bronchiectasis, chronic | 20 yrs. |
| Other Conditions Arteriosclerosis general. Arteriosclerotic heart disease (Include pregnancy within 3 months of death) | 20 yrs. |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Bachrach M. D.
Address Church Home & Hosp. Date signed Dec 14, 46

VS 130

107

G16192

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13A

Registered No. G16192

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) —

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Anne Arundel
(c) City or town Jacobsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Edith Hess EDITH MAY HESS

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widowed |

6 (b) Name of husband ~~or wife~~ Joseph E. Hess
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 4, 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 8 | 9 | hr. min. |

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Edward Jones
13. Birthplace Maryland

MOTHER
14. Maiden Name Ida May ?
15. Birthplace Md.

16 (a) Informant Edward Hess (Son)
(b) Address Jacobsville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa Aves. Balto. 17, Md.

19 (a) DEC 14 1946 (Date rec'd by registrar) (b) Huntington White Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 1946, at 2.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/12 1946 to 12/13 1946, and that I last saw ~~her~~ alive on 12/13 1946

| Immediate cause of death | Duration |
|---|---|
| Cerebro-vascular accident | 36 Hrs |
| Due to Hypertension | 3 yrs (?) |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John C. Morrison M.D.
Address Univ. Hospital Date signed 12/13/46

VS 150

G16193

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 107

G16193 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution:
University Hospital 9-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MARYLAND (b) County ——
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 910 E. 36th St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** PETER PELTO PETER B. PELTO

3 (b) If veteran, name war ——

3 (c) Social Security Account No. 215-03-9700

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | married |

6 (b) Name of husband or wife Marie Pelto
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) 1894 4/29/94

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 7 | 14 | hr. min. |

9. Birthplace Michigan (Town, county, and state)
10. Usual Occupation ~~XXXXXXXXXXXXXXXX~~ Dept Chief
11. Industry or business Western Elec. Co.

FATHER
12. Name Peter Pelto
13. Birthplace Norway

MOTHER
14. Maiden Name Ida Ball
15. Birthplace Norway

16 (a) Informant Marie Pelto — wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/46 (month) (day) (year)
(c) Cemetery ~~XXXXXXXXXX~~ Moreland Memorial Cem.
Location Balto. Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address NORTH & PA AVES BALTO 17, Md.

19 (a) (Date received by registrar) DEC 14 1946 (b) Huntington for William H. Hargett M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12-13 1946, at 1:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-12 1946 to 12-13 1946 and that I last saw him alive on 12-13 1946.

| Immediate cause of death | Duration |
|---|---|
| CONGESTIVE HEART FAILURE | |
| Due to BRONCHOPNEUMONIA | |
| Due to | |
| Other Conditions MACROCYTIC ANEMIA EXFOLIATIVE DERMATITIS (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Boorman M. D.
Address Univ. Hospital Date signed 12-13-46

VS 150

G6194 BC# G62941

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1194

Registered No. G6194

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution: St Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2432 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? Md. (Yes or No)
If yes, name country

3 (a) **FULL NAME** Thomas R. Hrehorotte.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/26/46

8. AGE: Years | Months | Days 15 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Child.

11. Industry or business

FATHER
12. Name Joseph H. Hrehorotte
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Doris L. Mason
15. Birthplace Pineville, Ky

16 (a) Informant Parents
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Bdlg

18 (a) Funeral director Leonard J. Kuck
(b) Address 530 S. Hanford St.

19 (a) DEC 14 1946 (Date rec'd by registrar) (b) Huntingtown Williamsport Md. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1946 at 10 00 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 12/5 1946 to 12/11 1946 and that I last saw h.. alive on 12/11 1946.

Immediate cause of death: Cardio Respiratory Failure.
Due to: Pneumonia Right Lung
Due to: Diarrhea, Dehydration
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John B. Wells
Address St Jos Hosp Date signed 12-11-46

G16195 BALTIMORE CITY HEALTH DEPARTMENT Dr. Cooley G16195

# CERTIFICATE OF DEATH 193D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 315 Diamond st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 315 Diamond st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Penny

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Emma

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 58 57 | Months | Days | If less than one day hr. min.

9. Birthplace Kentucky
(Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Emma Penny
(b) Address 315 Diamond St

17 (a) Burial (b) Date thereof 12-15-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Williams & Jackson
(b) Address 916 Penna ave

19 (Date received by Registrar) (b) Huntington Williams M.D.

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH See 12 1946, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1946 to Dec 12 1946
and that I last saw h alive on 12/12 1946.

| Immediate cause of death | Duration |
|---|---|
| (a) Pulmonary Heart Disease | |
| Due to (b) Congestive Failure | 2 yrs |
| Due to (c) | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Cooley M. D.
Address 315 Penna ave Date signed 12/15/46

G16196

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83A

Registered No. G16196

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 816 W Mulberry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 816 W Mulberry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie M Jones
3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex F
5. Color or race Col
6 (a) Single, married, widowed, or divorced. widowed
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 24 1874
8. AGE: Years 72 Months Days 17 If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation D
11. Industry or business

FATHER
12. Name Leonard Buxell
13. Birthplace Md

MOTHER
14. Maiden Name Mary Smith
15. Birthplace Maryland

16 (a) Informant George Moulton
(b) Address 816 W Mulberry St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto Md
18 (a) Funeral director Isaiah L Brown Son
(b) Address 1084 W Montgomery St
19 DEC 13 1946 (Date rec'd by registrar) Huntington W Va Burial, M

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/11/46 at 8 A M
21. I certify that death occurred on the date above stated, that I attended deceased from 12/6/1946 to 12/11/1946 and that I last saw h[illegible] alive on 12/11/1946
Immediate cause of death Cerebral Hemorrhage — Duration 1 day
Due to Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H C Cleave M. D.
Address 1181 Harlem Ave Date signed 12/14/46

VS 130

G16197 BCH BALTIMORE CITY HEALTH DEPARTMENT G16197
Registered No.

# CERTIFICATE OF DEATH

Y58895 64

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4823 Orville Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4823 Orville Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A Warren

3 (b) If veteran, name war: NV

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 13 1946

8. AGE: Years | Months: 2 | Days | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles G Warren
13. Birthplace Ga

MOTHER
14. Maiden Name Mary M Redcay
15. Birthplace Ga

16 (a) Informant Charles G Warren
(b) Address 4823 Orville Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec 14 46 (month) (day) (year)
(c) Cemetery or crematory Milton Penna
Location Pennsylvania

18 (a) Funeral director Wm Cook Sons
(b) Address 1217 St Paul St

19 (a) DEC 15 1946 (Date rec'd by Registrar) (b) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1946, at 11:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1946, to 19, and that I last saw him alive on Dec 13 1946.

| Immediate cause of death | Duration |
|---|---|
| Spontaneous Atelectasis | |
| Due to Enlarged thymus | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Conrad Gordon M. D.
Address 2201 W North Ave Date signed 12-14-46

G16198 G16198

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 F

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2209 Kentucky Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State N.Y. (b) County
(c) City or town New York City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Elizabeth F. Diepen

3 (b) If veteran, name war:

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F. | W. | Wid. |

6 (b) Name of husband or wife Theodore W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26-1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 6 | 17 | hr. min. |

9. Birthplace Brooklyn N.Y.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John J. Gillen
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant D. Von Kinteln
(b) Address 2209 Kentucky Ave.

17 (a) Removal (b) Date thereof 12/14/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lutheran
Location Fresh Pond Rd. L.I.

18 (a) Funeral director Wm Cook Inc.
(b) Address 222 St Paul St.

19 (a) (b)
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Dec. 13 1946; at M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1946 to 12/13 1946, and that I last saw h[illegible] alive on 12/13 1946

| Immediate cause of death | Duration |
|---|---|
| a Coronary Thrombosis | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howe Fuller M. D.
Address 670 3 Harford Ave. Date signed 12/14/46

VS 150

G16199

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13 A

G16199 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2441 N. Calvert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2441 N. Calvert St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ALETHIA R. LANE

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| W | [illegible] |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W. | W. |

6 (b) Name of husband or wife Samuel C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 2 | 11 | hr. min. |

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Solomon Rogerson
13. Birthplace N. C.

MOTHER
14. Maiden Name Rachel Chapel
15. Birthplace N. C.

16 (a) Informant Mrs J. M. Lane
(b) Address 2441 N. Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/46 (month) (day) (year)
(c) Cemetery or crematory Hartsdale N Y
Location Hartsdale N Y

18 (a) Funeral director Wilson & Son
(b) Address 1219 E. Fayette St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1946, at [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1946 to Dec 13 1946, and that I last saw her alive on Dec 11 1946

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Hypertensive Cardio Vascular renal disease | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. Horsefly M.D.
Address 601 N. Monroe St Date signed 12/14/46

G16500

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 130

G16500 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 839 Glade Court Balto (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Komaro KOMARO

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9, 1941

8. AGE: Years 5 | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace Shamokin Pa.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wasyl Komaro
13. Birthplace Penna.

MOTHER 14. Maiden Name Jenny Guzik
15. Birthplace Penna.

16 (a) Informant Mrs. Jenny Komaro
(b) Address 839 Glade Court Balto Md

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-16-46 (month) (day) (year)

(c) Cemetery or crematory
Location Shamokin Pa.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) Dec 16 1946 (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 1946 at 8:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6 1946 to Dec 14 1946 and that I last saw h alive on Dec 14 1946

| Immediate cause of death | Duration |
|---|---|
| Cerebral edema | |
| Due to Malignant Hypertension | |
| Due to Acute Glomerulo-Nephritis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Vincent A. Gazaleh, M.D.

Address 1 Balto Co Hosp Date signed 12/17/46

VS 150

K

G16501

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

G16501 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument St.
(c) Hospital or institution: Sinai Hospital 31
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 YRS

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(b) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 25 S. Eden St (If rural give location)
(c) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** LOUIS EISMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | WHITE | MARRIED |

6 (b) Name of husband or wife HOLLIE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | | | hr. min. |

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER 12. Name DAVID

13. Birthplace RUSSIA

MOTHER 14. Maiden Name SOPHIE

15. Birthplace RUSSIA

16 (a) Informant HOSPT RECORDS

(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-15-46 (month) (day) (year)

(c) Cemetery or crematory ROSEDALE

Location PHIL PO T HAMILTON AVE

18 (a) Funeral director JACK LEWIS INC

(b) Address 1439 E. BALTO ST

19 (a) 1946 (Date rec'd by registrar) (b) [illegible], Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 14 1946, at 1.03 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1946, to Dec 14 1946 and that I last saw h[illegible] alive on Dec 14 1946.

| Immediate cause of death | Duration |
|---|---|
| (a) Myocardial insufficiency | |
| Due to (b) Arteriosclerosis Myocardial fibrosis | |
| Due to (c) Arteriosclerotic Heart disease | |
| Other Conditions Pulmonary edema | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Heinz Beissinger M.D.

Address Sinai Hospital Date signed 12/15/46

VS 150

Write the cause of death clearly and correct age is especially important. Physicians: please write t

G16502

BC.G.66126

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 159

G16502

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address E. Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 N Bentalou St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Rottenberg

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 0 | Months | Days | If less than one day 23 hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Henry Rottenberg

13. Birthplace ?

MOTHER 14. Maiden Name Lodzia

15. Birthplace Russia

16 (a) Informant Hospital Admission

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-46 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location Jerusalem Rd

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E. Balto St.

19 (a) DEC 15 1946 (Date rec'd by registrar) (b) [illegible] Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13 1946, at 3:00 PM M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12, 1946, to Dec 13 1946, and that I last saw h.c.s. alive on 19

| Immediate cause of death | Duration |
|---|---|
| a Edematous ? | |
| Due to b Congen. Atelectasis ? | |
| Due to c | |
| Other Conditions ? | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: None

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edgar Stein M. D.

Address X Date signed

VS 3

G46503

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83A

Registered No. G46503

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Dukeland + Rayner Ave
(c) Hospital or institution: West Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) YY yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3734 Reed. Rd
(If rural give location)
(e) Citizen of foreign country? [illegible] (Yes or No)
If yes, name country

3 (a) FULL NAME Tobie Feldman

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widowed |

6 (b) Name of husband or wife Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Park Rd + Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St.

19 (a) (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12-14 1946 at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1 1946 to 12-14 1946, and that I last saw her alive on 12-14 1946

Immediate cause of death Acute Pulmonary Edema

Due to Cerebral Hemmorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

| Duration |
|---|
| |
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Berdiansky M. D.
Address West Balto Gen'l Date signed 11-14-46

VS 150

G16504

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 95c

G16504 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1537 No Smallwood St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1537 No Smallwood St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anna Glass

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Jack
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

| 8. AGE: Years | Months | Days | If less than one day hr. min. |
|---|---|---|---|
| 83 | | | |

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joe Flax
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Hyman Glass
(b) Address 862 Clover Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-46 (month) (day) (year)
(c) Cemetery or crematory Russdale
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Baltimore St

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12-13-1946 at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1941 to 12-13 1946, and that I last saw h[illegible] alive on 12-13 1946.

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | 15 min. |
| Due to Hypertension | |
| Chronic Hypertrophy | 5-10 yrs. |
| Due to Arteriosclerosis. | |
| Other Conditions Secondary Anaemia. | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Theodore Cooper M. D.
Address 2201 Eutaw Place Date signed 12/14/46

VS 150

Dr. Hagner G16505

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 D

Registered No. G16505

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4614 Mainfield Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4614 Mainfield Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Emma T. Moan

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | white | widowed |

6 (b) Name of husband or wife Frank M. Moan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25, 188

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 7 | 18 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Preston P. Keenan
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah E. Hudson
15. Birthplace Md.

16 (a) Informant Miss Rose Moan
(b) Address 4614 Mainfield Avenue

17 (a) Burial (b) Date thereof 12/16/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) DEC 15 1946 (b) Leon Williams, Registrar
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 13th, 1946 at 8:55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1946 to Dec. 13 1946 and that I last saw h[illegible] alive on Dec. 13 1946

Immediate cause of death Carcinoma of ... Duration 2 yrs

Due to

Due to

Other Conditions Carcinosis, Anemia

(Include pregnancy within 3 months of death)

Date of operation Sept. 1946

Major findings of operation Ca of ...

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Henry Hagner M. D.
Address 4218 Harford Rd. Date signed Dec 14 46

VS 150

G46506

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 56 E

G46506 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1818 W. Balto. St
(c) Hospital or institution:
70
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 W Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George L. Shaw

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Annie E. Warfield
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7-1859

8. AGE: Years 87 | Months 10 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Canning Manager (Retired)
11. Industry or business

FATHER
12. Name George Shaw
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Waidner
15. Birthplace Balto. Md

16 (a) Informant Mrs Miriam Shaw
(b) Address 1818 W Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Balto Md

18 (a) Funeral director Geo. L. Boyer Jr
(b) Address 1512 Hollins St

19 (c) DEC 15 1946 (Date rec'd by registrar) Hampton Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 1946 at 2 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1946 to Dec 14 1946 and that I last saw h alive on Dec 14 1946.

Immediate cause of death Pulmonary Bladder — Duration

Due to

Due to age

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A Evans M. D.

Address 612 N 40 St Date signed

VS 150

G16507

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94A

Registered No. G16507

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 610 S Decker Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 S Decker Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John B. Wells

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Fannie R. Wells
6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) July 13 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 5 | 1 | hr. min. |

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Real estate
11. Industry or business Retired

FATHER
12. Name George Wells
13. Birthplace Balto

MOTHER
14. Maiden Name Cordelia Lindemeyer
15. Birthplace Md

16 (a) Informant Harry E Wells
(b) Address 2729 E Monument St

17 (a) Burial (b) Date thereof Dec 17th
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (b)
(Signature of registrar) Registrar

DEC 15 1946

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14th 1946, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1946 to Dec 14 1946 and that I last saw h. alive on Dec 14 1946

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | 2 mos. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph LeKorny M.D.
M. D.
Address 2200 E Madison St Date signed 12/15/46

G16508

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

93D G16508

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3225 E. Fairmount Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3225 E. Fairmount Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Anna Mae Spivey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Elmer Spivey

6 (c) If alive, give age Years

7. Birth date of deceased (mo., day, yr.) July 25 1910

8. AGE: Years 36 | Months 4 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation housework

11. Industry or business

FATHER
12. Name Joseph Roth
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Frances Izdepska
15. Birthplace Baltimore Md.

16 (a) Informant Elmer Spivey
(b) Address 3225 E. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/46 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave

18 (a) Funeral director John F. Duda
(b) Address 2869 Hilldon Rd

19 (a) [illegible] (b) [illegible]
(Date received by local registrar) Washington Williams, Registrar

VS 3

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/12/46, at 9:10 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 12/6/46 to 12/12/46, and that I last saw h[illegible] alive on 12/12 1946.

Immediate cause of death: Acute Circulatory Collapse — Duration: 4 days
Due to: Chronic Nephritis — 18 yr.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence:
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature Matthew F. Newkomb M. D.

Address 1016 S Ann Ave Date signed 12/13/46

Dr. Laukeit
679 Washington Blvd.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

1310 G16509

Registered No. [redacted] G16509

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4203 Parkwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4203 Parkwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Stephen Hughes, Sr.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Emma E. Hughes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1880

8. AGE: Years 66 | Months 1 | Days 17 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Bureau Mech. Elect. Serv.

11. Industry or business

FATHER
12. Name Timothy Hughes
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Shea
15. Birthplace Ireland

16 (a) Informant Mrs. Emma E. Hughes
(b) Address 4203 Parkwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) [illegible] (b) [illegible]
(Date rec'd by registrar) [illegible] Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13th, 1946, at 11:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/6 1941 to 12/13 1946 and that I last saw h[illegible] alive on 12/13 19[illegible]

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia | 2 da |
| Due to Cerebral Hemorrhage | 2 da |
| Due to Hypertensive Cardiovascular Renal Disease | 10 yrs |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joseph G. Lauckeit
Address 679 Washington Blvd Date signed 12/14/46

VS 150

X

401825

BALTIMORE CITY HEALTH DEPARTMENT X G16510 Registered No.

G16519 CERTIFICATE OF DEATH 13B

[redacted]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.J. (b) County
(c) City or town Westfield (If outside city or town limits, write RURAL and give town)
(d) Street No. 541 Elm, St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Oliver H. York
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife Yvonne York
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 8-3-88

8. AGE: Years 58 | Months 4 | Days 1 11 | If less than one day hr. min.

9. Birthplace N.Y. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER 12. Name John H. York
13. Birthplace N.Y.

MOTHER 14. Maiden Name Mary C. Cook
15. Birthplace N.Y.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec 15 46 (month) (day) (year)
(c) Cemetery or crematory Burial City Line
Location Penbroke, New Hampshire

18 (a) Funeral director Philip McIntyre Funeral Home
(b) Address 2024 Guilford Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14 1946 at 10 50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16-1946 to 12-14-1946, and that I last saw him alive on 12-14-1946.

Immediate cause of death: Respiratory failure Uremia — Duration: ?

Due to: Tuberculosis - pulmonary — Duration: 2 yrs F

Due to: Tuberculosis - left kidney (ablated) —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11/11/46

Major findings of operation: TBC left kidney, ureter & bladder

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed 12-15-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X 46

G16511

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

G16511

## CERTIFICATE OF DEATH 131a

Reg. Dist. No. .....

**1. PLACE OF DEATH:**
County Balto. city
City or town 6028 Old Harford Rd. Baltimore, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7½ months
Hospital, institution, or street address where death occurred:
How long in hospital or institution? Beechhill, Nursing Home

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md. County St Marys
City or town Pearson, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. .....
(If rural, give LOCATION)
2.(a) If veteran, name war .....

**3.(a) FULL NAME** Mrs. Mary Emma Meredith

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6.(b) Name of husband or wife Thomas Meredith
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 1st 1863

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 2 | 14 | ..... hrs. ..... min. |

9. Birthplace Jackson, Iowa
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Benjamin Barton
13. Birthplace St. Thomas, West Indies

MOTHER
14. Maiden name Elizabeth Moody
15. Birthplace West Virginia

16. Informant Mrs. Frank Meredith
Address 22 Spa View Circle Annapolis Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 17th 1946 (month) (day) (year)
Cemetery or crematory Ebenezer,
Location California, Md.
18. Funeral director W. C. Mattingly Sons
Address Leonardtown, Md.
19. DEC 16 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15th 1946 at 9.40 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 16 1946 to Dec 15 1946 and that I last saw h.. alive on Dec 14 1946

| Immediate cause of death | DURATION |
|---|---|
| Chronic Glomer. Nephritis | |
| Myocardial Failure | |
| Due to Arteriosclerosis | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. .....
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE Lawrence C. Lobi M.D.
M. D. or other
Address 6805 York Road Date signed 12/15/46

G16512

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G16512 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2530 Druid Park Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Arthur L. Horwitz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Sadie G.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1888

8. AGE: Years 58 | Months 9 | Days 18 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation
11. Industry or business Woolens Business

FATHER
12. Name Moshe Horwitz
13. Birthplace Russia

MOTHER
14. Maiden Name Unkown
15. Birthplace Russia

16 (a) Informant Bernard Melvin Horwitz
(b) Address 2530 Druid Park Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec, 16, 1946 (month) (day) (year)
(c) Cemetery or crematory Sharrei Zion Cemetery
Location Hamilton Ave Rosedale

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Date filed by Registrar (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/15 1946, at 8:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10 1946, to 12/15 1946, and that I last saw h/im. alive on 12/15 1946.

Immediate cause of death Acute coronary occlusion — Duration

Due to Arteria sclerotic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Royal L Brown M. D.
Address Lorie Hosp Date signed 12/16/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46513

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 472a

Registered No. G46513

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland Calvert & Saratoga Sts.
(b) Street address 343 Clayton Ave.
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Just came

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Pa. (b) County
(c) City or town Waynesboro (If outside city or town limits, write RURAL and give town)
(d) Street No. 343 Clayton Ave. (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

**3 (a) FULL NAME** JACOB STONER

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife Mrs. Jacob Stoner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31 1861

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 85 | 1 | 16 | hr. min. |

9. Birthplace Pennsa. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Samuel Stoner
13. Birthplace Pa.

MOTHER
14. Maiden Name Sarah Best
15. Birthplace Pa.

16 (a) Informant Mrs. J. H. Stoner
(b) Address Waynesboro, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/46 (month) (day) (year)
(c) Cemetery or crematory Green Hill Cemetery
Location Waynesboro, Pa.

18 (a) Funeral director Walter H. Hoke
(b) Address 22 E. Church St. Waynesboro, Pa.

19 (a) (Date rec'd by registrar) (b) Huntington Hilliard Registrar

VS 186 DEC 16 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15 1946, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 3 1946, to Dec. 15 1946, and that I last saw him alive on Dec. 14 1946.

Immediate cause of death Bronchopneumonia — Duration 9 days

Due to Cardiac Failure

Due to

Other Conditions Cardiac Failure
Carcinoma of Larynx
(Include pregnancy within 3 months of death)

Date of operation Dec. 7, 1946

Major findings of operation: Carcinoma, Larynx

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James O'Hare M. D.
Address Mercy Hosp. Date signed 12/17/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16514

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G16514

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Church Home & Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 Dy.

(e) Length of stay in Baltimore (yrs., mos., or days) 0

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Penna (b) County

(c) City or town Hanover (If outside city or town limits, write RURAL and give town)

(d) Street No. R. Route #3 (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Charles Henry Bittinger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race white

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of ~~husband~~ or wife Minnie Bittinger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1879

8. AGE: Years 67 Months 10 Days 28 If less than one day hr. min. 11

9. Birthplace Hanover, Penna (City, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Mr. John L. Hauver

13. Birthplace Of Pennsylvania, Penna

MOTHER 14. Maiden Name Miss. Amanda Allwine

15. Birthplace Hanover, Penna.

16 (a) Informant Sister

(b) Address Hanover, Penna.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 18, 1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cemetery

Location Hanover Pa

18 (a) Funeral director W. A. Lauer

(b) Address Hanover Pa

(Date received) (b) Arlington Williams Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/15/46 19 , at 10:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/8/46 19 , to 12/15/46 , and that I last saw h[illegible] alive on 12/15/46 19 .

Immediate cause of death Cardiac failure — Duration

Due to arteriosclerosis

Due to Senile decay

Other Conditions Urinary retention from B.P.H.

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Joseph D. Antonioli M. D.

Address Church Home & Hosp. Date signed 12/15/46

VS 150

G16515

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1147

Registered No. G16515

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 616 Hubbard Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Lavine Stiles

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 38 | | | hr. min. |

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) Dec 18 (day) 46 (year)
(c) Cemetery or crematory Cemetery
Location Cambridge Md.

18 (a) Funeral director Lewis A Daugherty
(b) Address Cambridge Md.

19 (a) (Date received by registrar) (b) Lexington Williamsville (Registrar)

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12 1946 at 3 30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Lung abscess

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George E. Merrill M.D. (Medical Examiner.)
Date signed 12-23-46

G16516

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G16516

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2927 E. Monument St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2927 Monument
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

**3 (a) FULL NAME** Annie E. Long

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Conrad Long

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/25/79

8. AGE: Years 67 | Months 4 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Phillip Matkus

13. Birthplace Denmark.

MOTHER 14. Maiden Name ? ?

15. Birthplace ? ?

16 (a) Informant Mrs. Wm Dorn.

(b) Address 408 Oak Ave - Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/46 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Eastern Ave Bd.

18 (a) Funeral director Lilly & Zeile

(b) Address 403 N. Wolfe St

19 (a) DEC 1946 (Date received by registrar) Registrar

V 150

Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1946 at 2 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1946, to Dec 13 1946, and that I last saw h[illegible] alive on Dec 13 1946.

Immediate cause of death Coronary Thrombosis — Duration Sudden

Due to Arterio-Sclerotic Cardio Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas M. Baumgardner M. D.

Address Balto Md Date signed 12-9-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

D46517-

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G46517
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1910-Windsor Avenue
(c) Hospital or institution:
at employment - Cloverland Farms Dairy
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 531 Woodbourne Road.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** Edgar Hibbard (EDGAR PINKERTON HIBBERD)

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No. 212-20-8262

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Nettie M. Hibberd

6 (c) If alive, give age XX years

7. Birth date of deceased (mo., day, yr.) July 28, 1877

8. AGE: Years 69 XX | Months 4 | Days 15 | If less than one day ____hr. ____min.

9. Birthplace Carroll County, Maryland
(Town, county, and state)

10. Usual Occupation Employed by

11. Industry or business Cloverland Farms Dairy

FATHER
12. Name Eli Hibberd
13. Birthplace Carroll County, Md.

MOTHER
14. Maiden Name Mary Engler
15. Birthplace Carroll Co. Md.

16 (a) Informant Mrs. Thelma H. Algire (daughter)
(b) Address 531 Woodbourne Ave. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 16, 1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore City, Md.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (R. F. WOODS SUC.) 100 W. NORTH AVENUE

19 (a) (Date received by Local Registrar) (b) Registered

Dec 18 1946 Katie to Miller

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 13, 1946, at 10.25 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12-13-46

X

G16518
JL - 106817

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 1947

G16518
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2103 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Parrish

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-09-7737

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) July 20, 18[illegible]

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 4 | 23 | hr. min. |

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name Wm. Lee Parrish
13. Birthplace N. C.

MOTHER
14. Maiden Name Lillie Lockhardt
15. Birthplace N. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12/16/46
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery or ~~crematory~~ Balto.
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st

19 (a) (b)
(Date rec'd by registrar) Registrar

DEC 16 1946 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 13 1946, at 9.05PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12 1946 to Dec. 13 1946 and that I last saw h. im alive on Dec. 13 1946.

| Immediate cause of death | Duration |
|---|---|
| Cerebro-vascular accident | |
| Left hemiplegia | |
| Due to H.A.S.C.V. disease | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Doyle Waldron M. D.
Address B C H Date signed 12/14/46

X

G16519

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 130

G16519
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 700 N. Carey St
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 N. Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles Chandler

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | M |

6 (b) Name of husband or wife Frances F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/2/83

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 6 | 10 | hr. min. |

9. Birthplace Carey Co. Va.
(Town, county, and state)
10. Usual Occupation Jobber
11. Industry or business

FATHER
12. Name Thomas Chandler
13. Birthplace Va

MOTHER
14. Maiden Name Fenton Ranue
15. Birthplace Va

16 (a) Informant Frances F. Chandler
(b) Address 700 N. Carey St.

17 (a) Burial (b) Date thereof 12-16-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Balto. Co

18 (a) Funeral director Samuel W. Sullivan Jr
(b) Address 1011 N. Arlington Ave

19 (a) (b)
(Date received by registrar) Registrar

VS 3 DEC 16 1946

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Dec. 12 1946, at 5:10 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from 11/28 1946 to 12/12 1946 and that I last saw h alive on 12/12 1946

Immediate cause of death

a Polycythemia

Due to Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

| Duration |
|---|
| |
| |
| 2 wk |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature B. N. Hatch M.D.
Address 1212 E. N. Date signed 12/14/46

Attending Physician

X

b 46520

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

131B

G46520 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1606 Riggs Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1606 Riggs Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Margaret Emily Campbell

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | Widow |

6 (b) Name of husband or wife Samuel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4-1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 11 | 9 | hr. min. |

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Henry Dorsey
13. Birthplace Va.

MOTHER
14. Maiden Name Novella?
15. Birthplace Md.

16 (a) Informant Robert Campbell
(b) Address 1606 Riggs Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-16-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Catty

18 (a) Funeral director Samuel N. Thomas & Son
(b) Address 638 N. Gilmor St

19 (a) DEC 16 1946 (Date rec'd by registrar) (b) Registrar

VS 3

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 1946, at 2.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/6/1943 to 12/13/1946 and that I last saw h[illegible] alive on 12/13/1946

| Immediate cause of death | Duration |
|---|---|
| Acute Cardiac failure | |
| Due to Bronco Pneumonia and Arteriosclerosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Thorwell M.D.
Address 6017 Reisterstown Rd Date signed 12/16/46

B C#

G16521 P63657

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G16521

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Harford Rd & Herring Run
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 631 Wilson Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Henry Gerald Rasele

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| — | — |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 24 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| — | — | 21 d2 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business —

FATHER
12. Name Henry Rasele
13. Birthplace [illegible]

MOTHER
14. Maiden Name Jannita Schriefer
15. Birthplace Baltimore, Md.

16 (a) Informant Jannita Schriefer
(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof 12-17-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. & Ext

18 (a) Funeral director John G. Connelly
(b) Address 418 Eastern Ave

19 (a) DEC 16 1946 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

V S 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Dec 12 1946, at 10 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec 11 1946, to Dec 12 1946, and that I last saw him alive on Dec 12 1946

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure | |
| Due to Diphtheritic myocarditis | |
| Due to Laryngotracheobronchitis diphtheritic | |
| Other Conditions Contaminated | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature [illegible] M. D.
Address Sydenham Hosp. Date signed 12/12/46

G16522

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G16522 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Anne Arundel
(c) City or town Bay Ridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. #3 Bay Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** W. Ray Devilbiss Jr.

3 (b) If veteran, name war: World I

3 (c) Social Security Account No.: none

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of ~~husband or~~ wife: Anna May Devilbiss

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jun. 16, 1900

8. AGE: Years: 46 | Months: 5 | Days: 27 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Tavern Owner

11. Industry or business

FATHER
12. Name: W. Ray Devilbiss Sr.
13. Birthplace: Carroll Co. Md.

MOTHER
14. Maiden Name: Sophronia Baker
15. Birthplace: Union Bridge Md.

16 (a) Informant: Mrs. Wm J. Larkin, Daughter
(b) Address: 511 Stamford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/46 (month) (day) (year)
(c) Cemetery ~~Mausoleum~~: Woodlawn Cemetery
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS INC.
(b) Address: North & Pa Aves. Balto. 17, Md.

19 (a) (Date received by registrar) (b) Registrar

DEC 16 1946

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 13 1946, at 5:20 P M

21. I certify that I took charge of the remains described above, held an Aug & Insp. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary occlusion

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: William J. Hefferd M.D. Medical Examiner
Date signed Dec 14, 1946

G16523

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. G16523

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2414 Arunah Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2414 Arunah ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Milton Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Augusta Strube

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1886

8. AGE: Years 60 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Manager

11. Industry or business Farm + Farm

FATHER
12. Name Tyson Hill
13. Birthplace Md.

MOTHER
14. Maiden Name Edmonia Woods
15. Birthplace Md

16 (a) Informant Mrs. Augusta Hill
(b) Address 2414 Arunah Ave

17 (a) Burial (b) Date thereof 12/16/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Western
Location Edmondson Ave. + Longwood St.

18 (a) Funeral director Harry H. Veitsie

(b) Address 4101 Edmondson Ave.

19 (a) (b)
(Date rec'd by registrar) Registrar

DEC 16 1946 Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13/46 19 , at 8:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/6 1946 to 12/13 1946 and that I last saw him alive on 12/13 1946.

Immediate cause of death Uraemia — Duration

Due to Chronic nephritis

Due to Hypertensive cardio-vascular disease 6 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George W. Mountz Jr. M. D.
Address 320 W. Chas St. Date signed 12/14/46

X

G16524

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 56a

Registered No. G16524

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: Church Home & Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 24 years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5113 Greenwich Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

**3 (a) FULL NAME** Denise, Mrs Gladys

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | married |

6 (b) Name of husband or wife Mr Norris L Denise
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 10 1905

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 41 | 9 | 4 | hr. min. |

9. Birthplace Macon Georgia (Town, county, and State)
10. Usual Occupation Housewife
11. Industry or business none

FATHER
12. Name Bedingfield, Mallory
13. Birthplace Macon Georgia

MOTHER
14. Maiden Name Davis Georgia
15. Birthplace Macon Georgia

16 (a) Informant Deceased
(b) Address 5113 Greenwich ave Balt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 16 46 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn Md

18 (a) Funeral director Harry Hinkle
(b) Address 4101 Edmondson Ave

19 (a) DEC 16 1946 (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-14-46 19 , at 7:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-5-46 19 , to 12-14 19 46 and that I last saw her alive on 12-14 19 46

| Immediate cause of death | Duration |
|---|---|
| a Acute enterocolitis | 2 Days |
| Due to adhesions | |
| Due to Hysterectomy | 9 days ago |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 12-5-46
Major findings of operation: adhesions, Ovarian cyst,
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D S Cooley M. D.
Address Church Home & Hosp Date signed 12-17-46

Huntington Williams, M.D.

VS 150

AB-106433 G16525

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

50

G16525 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 Fisquith Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Rosa Bell Prince

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | Col. | Widow |

6 (b) Name of husband or wife Julius (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1-1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 8 | 10 | hr. min. |

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Giles Graves
13. Birthplace North Carolina

MOTHER
14. Maiden Name Mary Delancy
15. Birthplace North Carolina

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 16 46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location R. R. Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E Preston St

19 (a) DEC 1 1946 (Date rec'd by registrar) Registrar

VS 06

## MEDICAL CERTIFICATION

PM

20. DATE OF DEATH December 11 1946, at 7.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27- 1946 to 12-11- 1946 and that I last saw h. alive on 12- 11- 1946

Immediate cause of death Cardiac failure — Duration

Due to metastatic carcinoma of the breast

Due to

Other Conditions Hypertensive cardiovascular disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Metastatic Carcinoma of Breast

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin C. Evans M. D.
Address Balto. City Hospitals Date signed 12-13-46

G16526 BALTIMORE CITY HEALTH DEPARTMENT G16526

# CERTIFICATE OF DEATH 482

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4700 HARFORD AVE.
(c) Hospital or institution: CONVALESENCE HOME. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5YEARS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 N BENTALOU STREET.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** EMMA GERBER.

3 (b) If veteran, name war —
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widow |

6 (b) Name of husband or wife Henry J. Gerber
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3/20/73

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 8 | 24 | hr. min. |

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Frederick Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Henriett[illegible] ?
15. Birthplace Germany

16 (a) Informant Mary Bushheimer
(b) Address 822 N. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-17-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Wolfe St.

19 (a) (Date rec'd by registrar) (b)
DEC 16 1946

**MEDICAL CERTIFICATION** P.

20. DATE OF DEATH DECEMBER 13 1946 at 12.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from JANUARY 14 46 to DEC. 13 1946 and that I last saw h[illegible] or alive on DEC13. 1946

Immediate cause of death: CARCINOMIA OF UTERUS. JANY 14. 1946 — Duration
Due to METASTISIS. — 1946.
Due to CHRONIC ARTHRITIS DEFORMANS. 1940
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation NONE.
Major findings of operation: NONE
of autopsy: NONE

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 3013 SAINT PAUL ST. Date signed DECEMBER 13 1946.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G16527 BCH ✓ G16527

D61594

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

157a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2739 Ashland Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Frank Roh III

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/11/46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 1 | 2 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Roh Sr.
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mildred Peter
15. Birthplace Balto. Md.

16 (a) Informant Parents
(b) Address 2739 Ashland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director C. E. SCHIMMINEK.
(b) Address 2601 E. MADISON. ST

19 (a) DEC 16 1946 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13 1946, at 11:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 1946, to 12/13 1946 and that I last saw him alive on 12/13 1946.

| Immediate cause of death | Duration |
|---|---|
| Cardio respiratory failure | |
| Due to hydrocephalus internal | |
| Due to Spina Bifida & meningocaele | |
| Other Conditions Broncho-pneumonia | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address St. Joseph's Hospital signed 12/13/46 M. D.

X

G16528

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46E

Registered No. G16528

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2506 E. Eager St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Elizabeth Valentini

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-8-60

8. AGE: Years 86 | Months 7 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Home

11. Industry or business –

FATHER
12. Name Antonia Posseca
13. Birthplace Italy

MOTHER
14. Maiden Name Johnson
15. Birthplace Italy

16 (a) Informant Nicholas A. VALENTINI
(b) Address 2317 Ashland Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12/13/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd.

18 (a) Funeral director C. E. Schimpf
(b) Address 2601 E. Madison St. Baltimore, Md.

19 (a) ... (Date rec'd by registrar) ... Registrar

DEC 16 1946

VS 186

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 1946, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-8-1946, to 12-13 1946, and that I last saw him alive on 12-13 1946

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Cerebral Hemorrhage | 5 days |
| Due to Hypertensive Cardio-vascular disease | |
| Other Conditions | |

Carcinoma of lung, breast ?
(Include pregnancy within 3 months of death)
Date of operation –
Major findings of operation: –
of autopsy: –

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E. Farber M. D.
Address Bon Secours Hosp. Date signed 12-13-46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46529

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 168

G46529

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1308 Jefferson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ethel Lee Gibson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Sep

6 (b) Name of husband or wife: William Gibson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/3/24

8. AGE: Years: 22 | Months: 11 | Days: 8 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md (Town, county, and state)

10. Usual Occupation: Domestic

11. Industry or business

FATHER
12. Name: William Wilson
13. Birthplace: S. C.

MOTHER
14. Maiden Name: Virginia Dixon
15. Birthplace: Newport News, Va.

16 (a) Informant: Virginia Wilson Shaw
(b) Address: 1308 Jefferson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12/16/46 (month) (day) (year)
(c) Cemetery or crematory: Int Calvary
Location:

18 (a) Funeral director: Elroy D. Wilson
(b) Address: 1000 Brookley Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 19 DEC 16 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-11 1946, at 9 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Fractured skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-11-46 at Between 5 & 7:30 A.M.
(b) Where did injury occur? 1308 Jefferson St
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury: Blunt instrument

23. Signature: George L. Merrill M.D.
Medical Examiner.
Date signed 12/12/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16530

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G16530 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1151 Carroll St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1151 Carroll St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Thomas M Clark

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | white | Widowed |

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27th 1861

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 85 | 8 | 19 | hr. min. |

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation Glass Blower
11. Industry or business Clarisle Glass Co.

FATHER
12. Name John Clark
13. Birthplace Ireland

MOTHER
14. Maiden Name unknown
15. Birthplace Ireland

16 (a) Informant Mrs Leo J McCluskey
(b) Address 1151 Carroll St

17 (a) burial (b) Date thereof 12/17/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director John J Gowan & Son
(b) Address 2203 Wallbrook St.

19 (a) (b)
(Date received by registrar) Registrar

DEC 16 1945

VS 150

Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 13th 1946, at 1145 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Dec 13 1946 and that I last saw h[illegible] alive on Dec 13 1946

| Immediate cause of death | Duration |
|---|---|
| Acute Heart Failure | |
| Due to Myocarditis | |
| Due to Arteriosclerosis | |
| Other Conditions — | |

(Include pregnancy within 3 months of death)
Date of operation ✓
Major findings of operation: ✓
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis J Glorioso M. D.
Address 876 Valley Dr Date signed 12/16/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16531 BC# ✓ G16531

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 43

Registered No. 9 50646

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 631 S Belnord Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ronald A Laubling

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 5 | 10 | hr. min. |

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Victor Laubling
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Irene Lanocha
15. Birthplace Baltimore Md

16 (a) Informant Mrs Irene Laubling
(b) Address 631 S Belnord Ave Balto Md

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-16-46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location German Hill Rd.

18 (a) Funeral director Charles L. Zeiler
(b) Address 3605 Gait Ave.

19 (a) DEC 16 1946 (Date received by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 1946, at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1946, to Dec 14 1946, and that I last saw h in alive on Dec 14 1946.

| Immediate cause of death | Duration |
|---|---|
| Respiratory Failure | |
| Due to Pulmonary Mondia | |
| Due to Systemic Mondia | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Vincent J. Carrelson M.D.
Address 6 Balto Co. Hosp Date signed 12/17/46

VS 150

Carrelson X

G16532

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

G46532
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 425 E. 23rd St.
(c) Hospital or institution: Baltimore Md
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 425 E. 23 Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Cora Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John Bailey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21st 1896

8. AGE: Years 50 | Months 4 | Days 22 | If less than one day hr. min.

9. Birthplace Princessann Md
(Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER
12. Name Stephen Waters
13. Birthplace Md.

MOTHER
14. Maiden Name Lettie Waters
15. Birthplace Md

16 (a) Informant John Bailey
(b) Address 425 E. 23rd St

17 (a) Burial (b) Date thereof 12/18/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial
Location Balto County

18 (a) Funeral director Lottie Gross
(b) Address 1408 Eutaw St

19 (a) DEC 16 1946
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec. 13, 1946, at 2.55 P. M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 12-10-46 19 , to 12-13 1946, and that I last saw her alive on 12-11-46 19 .

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 days

Due to: uncertain

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M Rivkin Attorney

Address 238 N. Carey St Date signed 12-14-46

M. D.

VS 8

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46533

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13B

✓ G46533 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 625 George st.
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 625 George st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Carrie Barbee

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Negro | married |

6 (b) Name of husband or wife George Barbee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 34 | | | hr. min. |

9. Birthplace Jacksonville, N C
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Tom Wilson
13. Birthplace Kingston N.C.

MOTHER
14. Maiden Name Estella Marshall
15. Birthplace Jacksonville, N.C.

16 (a) Informant Fannie Dixon
(b) Address 625 George St.

17 (a) Burial (b) Date thereof Dec 16, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Durham
Location North Carolina

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 E. Schroeder St

19 (a) DEC 16 1946 Registrar
Date rec'd by local registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 13, 1946 at 3 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Miliary Tuberculosis of Lungs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Huntington M.D.
Medical Examiner.
Date signed 12-14-46

VS 191

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16534 B C# 160511 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G16534 Registered No.

# CERTIFICATE OF DEATH 119a

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Timonium (Rural)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 Belfort Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Regina Stein ✓

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: F.
5. Color or race: W
6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 23 1946

8. AGE: Years 0 | Months 01 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Baby
11. Industry or business

FATHER
12. Name George J Stein
13. Birthplace Maryland

MOTHER
14. Maiden Name Charlotte Oliver
15. Birthplace Maryland

16 (a) Informant Charlotte Stein
(b) Address 11 Belfort Rd-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/46 (month) (day) (year)
(c) Cemetery or crematory St Josephs Cemetery
Location Texas, Maryland

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) DEC 16 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 14 1946, at 9 55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-19 1946 to 12-14 1946 and that I last saw h[illegible] alive on 12-14 1946

Immediate cause of death: Cardio - resp. failure — Duration:
Due to Dehydration
Due to Neonatal diarrhea
Other Conditions Marasmus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E. May M.D.
Address Calvert & Saratoga Sts Date signed 12-14-46

VS 150

G46535
CWK-105558

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

131a

Registered No. G46535

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 19-
(e) Length of stay in Baltimore (yrs., mos., or days) 28 Yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2310 Guilford Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Jackson ~~Pendleton~~ Pendelton

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Married |

6 (b) Name of husband or wife Esther
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3-1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 6 7 | 11 | hr. min. |

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Jackson
13. Birthplace Virginia

MOTHER
14. Maiden Name Patsy Thornton
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 17/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A. A. County Md

18 (a) Funeral director Mrs Kath'g. Elliott - Dept
(b) Address 1129 N. Caroline St

19 (a) (Date rec'd by registrar) (b) Registrar

Hunting for Will

VS 150 DEC 16 1946

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** December 14 1946 at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 25 1946 to Dec. 14 1946 and that I last saw him alive on Dec. 14 1946.

Immediate cause of death Uremia — Duration

Due to H C Uremal Anuria

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Doyle Waldron M. D.
Address BCH Date signed 12/14/46

X

G16536 BALTIMORE CITY HEALTH DEPARTMENT ✓ G16538
CERTIFICATE OF DEATH 94a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2505 Morganstreet
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) All 48yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2505 Morganstreet (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louise Jones (Martin)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex fem. | 5. Color or race col. | 6 (a) Single, married, widowed, or divorced. married
6 (b) Name of husband or wife Sunney Jones
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) DEC-4-1874

8. AGE: Years 72 | Months 0 | Days 9 | If less than one day hr. min.

9. Birthplace Faulkner Charles County. (Town, county, and state)
10. Usual Occupation Housework.
11. Industry or business

FATHER 12. Name Hob Henry Fenrick
13. Birthplace Charles County

MOTHER 14. Maiden Name Josephine (not known) Mazie Matthews
15. Birthplace Charles County.

16 (a) Informant James Fenrick
(b) Address 2505 Morganstreet.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 17/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem.
Location West part

18 (a) Funeral director Wm. R. A. Elliott & Daughter
(b) Address 1129 N. Caroline St.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 18 1946

VS 189 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH December-13-1946, at 8 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov-29-1946 to Dec-12-1946, and that I last saw h alive on Dec-12-1946

Immediate cause of death Occlusion of coronary artery of the heart. — Duration
Due to Arteriosclerosis
Due to
Other Conditions Hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter H. Sonnenfeldt M. D.
Address 2505 Morganstreet Date signed 12/17/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BCH

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore, City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-month
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 651 W. Barre St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harvey Baby Girl ( Marie )
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13/ 1946

8. AGE: Years | Months: 1 | Days: - | If less than one day: hr. min.

9. Birthplace Baltimore , Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Reginald Harvey
13. Birthplace Maryland

MOTHER
14. Maiden Name Marie Moore
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records )

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 16/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location a. A. County

18 (a) Funeral director Mrs Robt A. Ellis & Dept
(b) Address 1129 N. Carrollo St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13th 1946, at 5.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13th 1946 to Dec 13 1946 and that I last saw h. er alive on Dec/13 1946

Immediate cause of death: Prematurity — Duration: Life

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes M. D.
Address Balto City Hosp Date signed Dec 14/46

VS 150

DEC 16 1946

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JL - 102002 G16538

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13B

G16538 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 - 2
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mikeuzema Grant

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 11 | 29 | hr. min. |

9. Birthplace Texas
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Israel
13. Birthplace Texas

MOTHER
14. Maiden Name Onie Graves
15. Birthplace Texas

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/46 (month) (day) (year)
(c) Cemetery or crematory Kansas
Location Topeka Kansas

18 (a) Funeral director Geo. D. Kelson
(b) Address 1303 Pressstman St

19 (a) (Date received by registrar) (b) Registrar

DEC 16 1946

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 1946, at 5.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1946 to Dec. 14 1946. and that I last saw h im alive on Dec. 14 1946

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Pulmonary Tuberculosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Dayle Waldron M. D.
Address B C H Date signed 12/16/46

X

Dr. Pokorny

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1946

Registered No. 6[illegible]539

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 812 N. Madeira st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 812 N. Madeira st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Joachim Vieira

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Joseph Vieira
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16 68

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 84 | 8 | 27 | hr. min. |

9. Birthplace Bohemia (Town, county, and state)
10. Usual Occupation housework
11. Industry or business

FATHER
12. Name Joseph Pachole
13. Birthplace Bohemia

MOTHER
14. Maiden Name Not Known
15. Birthplace Bohemia

16 (a) Informant Emma C. Vieira
(b) Address 812 N Madeira

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 17/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Frank Leach & Son
(b) Address 900 N. Chester st

19 (a) [illegible] (Date rec'd by registrar) (b) [illegible] Registrar

DEC 20 1946

VS-150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1946 to Dec 13 1946.
and that I last saw her alive on Dec 11 1946

Immediate cause of death

Due to Coronary Thrombosis — Duration 2 mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Pokorny M. D.
Address 2200 E. Madison Date signed 12/14/46

X

G16540

505846

BALTIMORE CITY HEALTH DEPARTMENT X

# CERTIFICATE OF DEATH 157E

Registered No. G16540

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State N.Y. (b) County
(c) City or town Poughkeepsie (If outside city or town limits, write RURAL and give town)
(d) Street No. 270 Church St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Karen M. McCormack

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-19-45

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 1 | 3 | 25 27 | hr. min. |

9. Birthplace New York. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Ronin McCormack
13. Birthplace N.Y.

MOTHER 14. Maiden Name Vivian Hoyt.
15. Birthplace Mass.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/46 (month) (day) (year)
(c) Cemetery or crematory
Location Poughkeepsie N.Y.

18 (a) Funeral director John C. Miller Inc.
(b) Address 2436 E. Eutaw St.

19 (a) (b) (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH: Dec. 15 1946, at 11.47 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 5- 1946, to Dec. 15 1946, and that I last saw h[illegible] alive on Dec. 15 1946.

Immediate cause of death: Congenital Heart disease + Cyanosis — Duration: Life

Due to

Due to

Other conditions Possible tracheal atresia

(Include pregnancy within 3 months of death)

Date of operation 12/1/46

Major findings of operation: Pulmonary Atresia

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry L. Sahyun
Address 12/16/46 Johns Hopkins Hosp. Date signed M.D.

VS 150 Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G16541

LN. G16541 106616

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2214 N. Howard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Pauline Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Col | Separated |

6 (b) Name of husband or wife Walter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 26th 1925

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 21 | 3 | 11 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lewis (Elliott) Elliott
13. Birthplace Pa.

MOTHER
14. Maiden Name Hattie Washington
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 16 (Month) (day) (year)
(c) Cemetery or crematory Elkton Md.
Location

18 (a) Funeral director A Halsted
(b) Address 918 S. Broadway

19 (a) (Date rec'd by registrar) Dec 16 1946

VS Dec 16 1946 Huntington Hall

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec/13th 1946, at 7.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec/4th 1946 to Dec. 13 1946, and that I last saw her alive on Dec/13th 1946.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Disseminated tuberculosis | |
| Due to mycobacterium tuberculosis | |
| Other Conditions Tuberculous meningitis, tuberculous peritonitis | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Disseminated tuberculosis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin C. Evans M. D.
Address Baltimore City Hospitals Date signed 12-14-46

X

Birth certificate

G-644444

G46532

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

Registered No. G46532

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address Bon Secours Hosp 1854

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 1/2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State — (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1926 Mosher St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

**3 (a) FULL NAME** Leroy Henry Haupt Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W. | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/10/46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 5 1/2 | hr. min. |

9. Birthplace Baltimore, MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER 12. Name Leroy Henry Haupt

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Margaret Elizabeth Ford

15. Birthplace Baltimore Md

16 (a) Informant Mother

(b) Address 1926 Mosher St Apt 2

17 (a) Burial (b) Date thereof 12/16/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lorraine Park

Location Woodlawn, MD

18 (a) Funeral director John F. Denny, Inc.

(b) Address 715 Light St.

19 (a) (b)
(Registrar's signature) (Date received by registrar) DEC 16 1946 Registrar, MD

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 12/15/46 19 at 5:25 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 12/9/46 19 to 12/15/46, and that I last saw h alive on 12/9/46 19

| Immediate cause of death | Duration |
|---|---|
| Cardio-respiratory failure | |
| Due to Premature birth | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

**23. Signature** E. H. Scott Jr. M. D.

Address Bon Secours Hosp Date signed 12/15/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G16543

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 57E

G16543 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2117 Denison St.
(c) Hospital or institution:
Crawford Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County A. A.
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 162 West St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** WALTER R. BRESLIN

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| None | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Laura M. Breslin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 10 | 27 | hr. min. |

9. Birthplace London, England
(Town, county, and state)
10. Usual Occupation Retired- Hotel Operator
11. Industry or business Self

FATHER
12. Name Unknown Breslin
13. Birthplace England

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Laura M. Breslin, Wife
(b) Address 162 West St. Annapolis, Md.

17 (a) Burial (b) Date thereof 12/17/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baldwin Mem. Cem.
Location Severn Crossroad Md. A. A. Co.

18 (a) Funeral director Wm. J. TICKNER & SONS INC.
(b) Address North & Pa Aves. Balto. 17, Md

19 (a) (Date received by registrar) (b) Huntington Williams

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 12/14/46 19 at 9:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9- 1946 to 12-14 1946, and that I last saw h alive on 12-14 1946.

| Immediate cause of death | Duration |
|---|---|
| (a) Uremia | about 3 days |
| Due to (b) Bronchial Pneumonia | about 4 days |
| Due to (c) Tumor Left Kidney | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. P. Bizzoso M. D.
Address 410 Medical Arts Bldg Date signed 12/16/46

VS 150

X

G16541

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 152

G16544 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2512 Laurella ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Marion Newton Hardin
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex male
5. Color or race white
6 (a) Single, married, widowed, or divorced. married
6 (b) Name of husband or wife Amelia Hardin
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 27 1894
8. AGE: Years 51 yrs. Months 3 Days 14 If less than one day hr. min.
9. Birthplace Indiana (Town, county, and state)
10. Usual Occupation Miner
11. Industry or business

FATHER
12. Name Marion Hardin
13. Birthplace Indiana

MOTHER
14. Maiden Name Madeline Phillips
15. Birthplace Indiana

16 (a) Informant Mrs. Amelia Hardin
(b) Address 2512 Laurella ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 16 1946 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto Co

18 (a) Funeral director E. Howard Evans
(b) Address 1440 Pennsylvania

19 (a) DEC 16 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/15/46 19 at 12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/13/46 to 12/15/46, and that I last saw h[illegible] alive on 12/15/46

Immediate cause of death cardiac failure

Due to

Due to

Other Conditions arteriosclerosis, left hemi.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph D. Thurston M. D.
Address Church Home & Hosp. Date signed 12/17/46

G46545

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

Registered No. G46545

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 819 Harlem Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 819 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARTHA A. RYAN

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | Married |

6 (b) Name of husband or wife Henry Ryan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 3 | 29 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Bose
13. Birthplace Md.

MOTHER
14. Maiden Name Hester Collins
15. Birthplace Md.

16 (a) Informant Mr. Henry Ryan
(b) Address 819 Harlem Ave.

17 (a) Burial (b) Date thereof 12-17-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (b)
(Date rec'd by registrar) Registrar

DEC 16 1946 Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION** A

**20. DATE OF DEATH** December 13 19 46 at 6:30 M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 8/16/46 to 12/13/46.
and that I last saw h[illegible] alive on 12/12/46
Immediate cause of death Rupture
Intestinum

| Duration |
|---|
| 3 hrs |

Due to Peritonitis Multiple Gunshot Wounds Abdomen
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 12-14-46

X

Brown G46546

G46546

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 E. Preston
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 E. Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Henry E. Posedom

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ulia Posedom

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Nov-27-1878

8. AGE: Years 68 | Months - | Days 17 | If less than one day hr. min.

9. Birthplace Jamaica, B. W. I.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Henry Posedom
13. Birthplace Jamaica, B.W.I.

MOTHER
14. Maiden Name Deanna ?
15. Birthplace Jamaica B.W.I.

16 (a) Informant Mrs. Ulia Posedom
(b) Address 1514 E Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-17-1946 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Parks
Location Arbutus Maryland

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St.

19 (a) DEC 16 1946 (Date rec'd by Registrar) (b) Huntington Williams Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 1946 at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-21 1946 to 12-14 1946 and that I last saw him alive on 12-14 1946

Immediate cause of death: Coronary occlusion — Duration: 3 wks

Due to hypertensive cardio-renal disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1500 E. Madison St Date signed 12-16-46

VS 150

Rayner Brownlee x

G46547

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 87c

G46547 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:** 1574 Division St.
(a) Baltimore City, Maryland
(b) Street address 1422 McCulloh St.
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 72-9-15

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1422 McCulloh St
(If rural give location)
(e) Citizen of foreign country? W. (Yes or No)
If yes, name country

**3 (a) FULL NAME** Gaines R. Cook

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Bertha M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27 1874

8. AGE: Years 72 | Months 9 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Custodian

11. Industry or business

FATHER
12. Name Thomas Cook
13. Birthplace Annapolis, Md.

MOTHER
14. Maiden Name Henrietta Gaines
15. Birthplace Frederick, Md.

16 (a) Informant Mrs. Mary Brooks
(b) Address 1422 McCulloh St

17 (a) Burial (b) Date thereof Dec 16, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md

18 (a) Funeral director Jno. Lee & H. Holland
(b) Address 16 [illegible] Druid Hill Ave.

19 (a) ..... (b) ..... Registrar
(Delivered by registrar)

Dec 16 1946 Huntington Williams M.D.

V S 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 17 December 1946 at 1:30 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from September 1944 to 12 Dec. 1946, and that I last saw him alive on 12 Dec. 1946.

| | Duration |
|---|---|
| Immediate cause of death: Hypostatic pneumonia | 48 hrs. |
| Due to: Laceration | 2 wks. |
| Due to: arteriosclerosis, generalized | 2 yrs. |
| Other Conditions: paralysis agitans | 2 yrs. |

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work?
(Specify type of place)
(e) Means of injury

**23. Signature** James D. Carr M. D.

Address 515 Morley St Date signed 12.14.46

X

G46548

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

Registered No. G16548

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 109 S. Loudon Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland County Baltimore
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 109 S. Loudon Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Anderson Seicke

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: John H. Seicke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20 1879

8. AGE: Years 76 | Months 5 | Days 24 | If less than one day hr. min. 1870

9. Birthplace Arlington, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Fernandouse Bowen
13. Birthplace Towson, Md.

MOTHER
14. Maiden Name Rachel Ann Everett
15. Birthplace Chestnut Ridge Md.

16 (a) Informant Mrs. Mamie Yakel
(b) Address 109 S. Loudon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 17, 1946 (month) (day) (year)
(c) Cemetery or crematory Salem Lutheran Location Dogwood Ave., Catonsville

18 (a) Funeral director Easton Sons
(b) Address 608 Frederick Ave. Catonsville

19 (a) (b) (Delivered by registrar) Registrar

DEC 18 1946

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14, 1946 at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17 1942 to 12-14 1946 and that I last saw h er alive on 12-13 1946

| | Duration |
|---|---|
| Immediate cause of death: Coronary Thrombosis | 4 days |
| Due to: Arterio-Renal-Vascular Dis. | 4 yrs.? |
| Due to: Hypertension | 4 yrs.? |
| Other Conditions: Diabetes | 11 yr. |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George E. Wolfe M. D.
Address Catonsville, Md. 28 M Date signed 12-14-46

1310

G16519

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G16519 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Dwk
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 528 W. Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles Savage

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | C | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1-1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | 8 | 15 | hr. min. |

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " "

MOTHER
14. Maiden Name "
15. Birthplace " "

16 (a) Informant Mary Bertha Jones
(b) Address 528 W Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-19-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 915 West Hill Ave.

19 (a) (Date rec'd by Registrar) (b) Functioning for Williams, M.D. Registrar

DEC 16 1946

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/16 1946, at 5:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C-V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Gilbreath M.D. Medical Examiner.
Date signed 12/16/46

X

G16550

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

12/31/B

G16550 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2402 Guilford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2402 Guilford Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Alice Maude Lemmon Schnibbe

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18, 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | July | 25 | 17 hr. 10 min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Asbury
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Alice Lemmon
15. Birthplace Baltimore Md

16 (a) Informant Miss Katharine Sikes
(b) Address 2402 Guilford Ave.

17 (a) Burial (b) Date thereof 12 17 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem
Location

18 (a) Funeral director Wardefield & Son
(b) Address 501 E. Preston St.

19 (a) (Date rec'd by registrar) (b) Waiting for Williams M.D. Registrar

DEC 16 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 1946, at 12-10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1945 to Dec. 14 1946, and that I last saw her alive on Dec. 14 1946.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Edema | 24 hrs |
| Due to Chronic Myocarditis | 2 yrs |
| Due to Chronic Nephritis | 2 yrs |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. T. Sale M. D.
Address 6014 York Road Date signed 12-14-46

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46551

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

Registered No. G46551

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital, Baltimore 2, Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3307 Elbert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Josephine M. Pidge

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | married |

6 (b) Name of husband or wife Harry L. Pidge
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 7 | 11 | hr. min. |

9. Birthplace Connecticut Fairfield
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Bluske
13. Birthplace Germany

MOTHER
14. Maiden Name Anna ?
15. Birthplace Unknown

16 (a) Informant Mr. Harry L. Pidge
(b) Address 3307 Elbert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/46 (month) (day) (year)
(c) Cemetery ~~xxxxxxxxx~~ Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa Aves. Balto. 17, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 16 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15 1946, at 9:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 14 1946 to Dec. 15 1946 and that I last saw h[illegible] alive on Dec. 15 1946

Immediate cause of death: Generalized Carcinomatosis — Duration

Due to Metastasis from Carcinoma of Rt. breast

Due to

Other Conditions Rt. hydronephrosis and hydroadenosis of Rt. Adrenal

(Include pregnancy within 3 months of death)

Date of operation August, 1945

Major findings of operation: Carcinoma of right breast

of autopsy: not done

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Robert E. McCurdy M. D.
Address University Hosp. - Date signed 12/15/46

Huntington Williams, M.D. Registrar

X

G16552

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G16552 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3039 Strickland
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3039 Strickland
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES FALK CHARLES H. FALK

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 215-07-1215

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ wife Frieda E. Falk

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1897

8. AGE: Years 79 | Months 0 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual Occupation General Foreman

11. Industry or business Balto. Salesbook Co.

FATHER
12. Name Frank Falk
13. Birthplace Ohio

MOTHER
14. Maiden Name ? Moore
15. Birthplace Ohio

16 (a) Informant Mrs. Charles Falk, Wife
(b) Address 3039 Strickland St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/46 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Loudon Park Cem.
Location Baltimore Md.

18 (a) Funeral director WM. J. TICKNER & SONS, INC.
(b) Address North & Pa Ave. Balto. 17, Md.

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/15/46 19..., at 7:00 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 12/16/46

VS 151

X

G46553

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 52a

G46553 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Mercy Hospital
(c) Hospital or institution: Saratoga & Calvert Sts
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44d
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3714 Kimble Rd.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Albert C. Bradley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife Genevieve Bradley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18, 1878

8. AGE: Years 68 | Months 6 5 | Days 2 28 | If less than one day hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name John J. Bradley
13. Birthplace Md

MOTHER
14. Maiden Name Rose Rash
15. Birthplace Md.

16 (a) Informant Albert C. Bradley
(b) Address 3714 Kimble Rd.

17 (a) Burial (b) Date thereof 12/19/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Pk.
Location Baltimore, Md.

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) 1946 (b)
(Date rec'd by registrar) Huntington Mill Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-16- 1946, at 4A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 18 1946, to Dec 16 1946, and that I last saw him alive on Dec. 16 1946.

| | Duration |
|---|---|
| Immediate cause of death Heart Failure | |
| Due to Coronary Heart Disease | |
| Due to | |
| Other Conditions Ca. of Left Kidney with Metastasis | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James V. Minor, Jr. M. D.
Address Mercy Hosp Date signed 12/19/46

X

G46554 Smith M. 3429 Chestnut Ave Dr G46554 Wilson Wm

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G46554

Change date of Attendance

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 812 E. 33rd St Balto Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Daniel J. Costello

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | white | widowed |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1869

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 76 | 6 5 | 21 | hr. min. |

9. Birthplace Newfoundland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Costello
13. Birthplace

MOTHER
14. Maiden Name Margaret Humphries
15. Birthplace England

16 (a) Informant Mrs Cecelia O'Brien
(b) Address 812 E. 33rd St Balto Md

17 (a) Removal (b) Date thereof 12/17/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Paul's
Location Arlington, Mass.
18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul St
19 (a) (b)
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 15 1946, at 1:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13 1946, to 12-15 1946, and that I last saw him alive on 12-15 1946.

| Immediate Cause of death | Duration |
|---|---|
| Coronary thrombosis | 2 days |
| Due to Coronary occlusion | |
| Due to | |
| Other Conditions Myocardial infarction | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 3429 Chestnut Ave Date signed 12/16/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G16555

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 47D

G16555
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Madison & Howard
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Conn. (b) County
(c) City or town New London
(If outside city or town limits, write RURAL and give town)
(d) Street No. 147 Bank Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Byers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary E Byers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 3 1890

8. AGE: Years 5-6 | Months 2 | Days 10 | If less than one day hr. min.

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation Chief Inspector

11. Industry or business Am Export Line

FATHER
12. Name Henry Byers
13. Birthplace Ny York

MOTHER
14. Maiden Name Sarah Fallon
15. Birthplace Ember Comado

16 (a) Informant Mary E
(b) Address Same

17 (a) Burial, cremation, or removal (b) Date thereof 12/16/46
(month) (day), (year)
(c) Cemetery or crematory Cedar Grove
Location New London Conn.

18 (a) Funeral director Gilman Conlon
(b) Address 129 Golden St

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1946 at 10 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1946 to Dec 13 1946 and that I last saw h[illegible] alive on Dec 13 1946

Immediate cause of death: Acute Cardiac Failure — Duration

Due to: Hypertension & Nephritis

Due to:

Other Conditions: Carcinoma Lung, Rt.
(Include pregnancy within 3 months of death)

Date of operation Dec 12 1946

Major findings of operation: Carcinoma Lung Rt

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter C Shelburne M. D.
Address Med Cen Hosp Date Dec 15 1946

VS 150

G16556 G16556

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 186a

Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 0

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County St. Mary's
(c) City or town Helen
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Mattingly Swann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-9-53

8. AGE: Years 93 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Retired farmer

11. Industry or business

FATHER
12. Name Benjamin Swann
13. Birthplace Md.

MOTHER
14. Maiden Name Lucinda Mattingly
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 19-1946 (month) (day) (year)
(c) Cemetery or crematory M.E. Cemetery
Location Chaptico, Md.

18 (a) Funeral director W.C. Mattingly Sons
(b) Address Leonardtown, Md.

19 (a) DEC 17 1946 (Date rec'd by registrar) (b) Signature for Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16 1946, at 7:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 1946 to Dec. 16 1946 and that I last saw him alive on Dec. 16 1946.

Immediate cause of death ARTERIOSCLEROTIC Cardiac — vascular, respiratory failure, post-operative — Duration

Due to

Due to

Other Conditions Fracture, intertrochanteric at femur.
(Include pregnancy within 3 months of death)

Date of operation Dec 15 1946

Major findings of operation: FRACTURE INTERTROCHANTERIC AT FEMUR

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 12-8-1946 at — M
(c) Where did injury occur? Helen, St. Mary's Co. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury: Fell from chair in kitchen

23. Signature Edmund J. McDonnell M. D.
Address Johns Hopkins Hosp. Date signed Dec 17 1946

Com. B. Helbrick Md. Pat. Thomas J. Canavan, Jr. M.D.

G16557 BC#. BALTIMORE CITY HEALTH DEPARTMENT Registered No. G46557

AB-106351 B 62867 CERTIFICATE OF DEATH 1160a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1030 S. Sharp St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Baby Boy Lemon

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25-1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 15 | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Elijah Lemon
13. Birthplace ?

MOTHER
14. Maiden Name Orethe Robertson or Robinson
15. Birthplace Baltimore, Maryland

16 (a) Informant 4940 Eastern Ave-Baltimore
(b) Address City Hospitals Records

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 12-13-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) DEC 17 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 10 1946 at 8.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 25 1946 to 12-10- 1946, and that I last saw h. im alive on 12-10- 1946.

Immediate cause of death: Intracranial Hemorrhage — Duration Life
Due to: Prematurity — Duration Life
Due to — Duration
Other Conditions — Duration
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: same

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William E. Hughes M.D.
Address Balto City Hosp Date signed Dec 15 46

VS 150

G16558 BCH BALTIMORE CITY HEALTH DEPARTMENT G16558
JL - 106774 G64709 CERTIFICATE OF DEATH 30F Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr-45m
(e) Length of stay in Baltimore (yrs., mos., or days) 1 hr- 45min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 385 Hillen Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Johnson- Martha

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1946

8. AGE: Years | Months | Days | If less than one day: 1 hr. 45 min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel Houston
13. Birthplace N. Y.

MOTHER
14. Maiden Name Martha Jane Johnson
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 12-13-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4946 Eastern Ave.

18 (a) Funeral director
(b) Address

19 DEC 17 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1946, at 7.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 10 1946 to Dec. 10 1946, and that I last saw h. alive on Dec. 10 1946.

Immediate cause of death: Congenital syphilis — Duration: life
Due to
Due to
Other Conditions: Pneumonia, Prematurity
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes M. D.
Address Balto. City Hosp. Date signed Dec 13 '46

VS 150

G16559

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 108

G16559 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1707 N. Monroe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 N. Monroe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jerome Seymour Wilkinson

3 (b) If veteran, name war W

3 (c) Social Security Account No. None

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Helen Wilkinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 8th 1905

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 41 | 9 | 8 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name James Wilkinson
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Lillian Glenn
15. Birthplace Balto. Md.

16 (a) Informant Helen Wilkinson
(b) Address 1707 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) [illegible] (Date received by registrar) Huntington Williams M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16th 1946 7:30 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1946 to Dec 16 1946 and that I last saw h/M alive on Dec 15 1946

| Immediate cause of death | Duration |
|---|---|
| Pneumonia | over |
| Due to Myocarditis | |
| Due to Hypostatic Disturbance | |
| Other Conditions Leslie Morton ex Workabout 4 months | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter A Anderson M.D.
Address 3601 Shannon Drive #13 Date signed

X Dec. 16-46

G16560

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G16560 Registered No. 1316

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1809 Braddish Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 Braddish Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma E. Thomas

3 (b) If veteran, name war —

3 (c) Social Security Account No. NONE

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Joseph Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 25th 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 8 | 20 | hr. min. |

9. Birthplace Housewife (Town, county and state)

10. Usual Occupation Balto. Md

11. Industry or business Own Home

FATHER 12. Name John H. Bruns

13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Stallknecht

15. Birthplace Balto Md

16 (a) Informant Mabel Streckfus

(b) Address 2617 E. Hoffman St.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 12/18/46 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15th 1946, at 145 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1946, to Dec. 15 1946 and that I last saw h[illegible] alive on Dec 15th 1946

Immediate cause of death Uremia — Duration 2 days

Due to Chr. Nephritis — 4 wks

Due to Chr. Glomerulitis — 8 mos.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Jan Eberwein M. D.

Address 1136 Park Ave Date signed 12/17/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46561

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 156E

G46561 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 300 S. Collington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 300 S. Collington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** DOLORES MARIE RUTKOWSKI

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 15 1928

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 18 | 3 4 | 29 | hr. min. |

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Albert Rutkowski
13. Birthplace Baltimore

MOTHER
14. Maiden Name Julia Biedronski
15. Birthplace Baltimore

16 (a) Informant Albert Rutkowski
(b) Address 300 S. Collington Ave.

17 (a) Burial (b) Date thereof Dec. 18/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozgeurski
(b) Address 1930 Eastern Ave.

19 (a) (b)
(Date rec'd by registrar) Registrar

DEC 17 1946

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 1946, at 7a M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 4 1946 to Dec. 14 1946 and that I last saw h.er alive on Dec 14 1946

Immediate cause of death Neurofibromatosis — Duration 10 yrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert Goldstone M. D.
Address 1143 Linden Av. Date signed Dec. 16

G16562

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1246

G16562

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 of N Wheeler Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** J Harry Tolson

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Widowed |

6 (b) Name of husband or wife Catherine M
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 2 | 17 | hr. min. |

9. Birthplace Mary Land
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name George Tolson
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Will
15. Birthplace Germany

16 (a) Informant Harry C Norwood
(b) Address 1114 N Bethel St

17 (a) Burial (b) Date thereof 12-18-41
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Sepulchre
Location Back Rd

18 (a) Funeral director Joseph A Shirley
(b) Address Fulton & Fayette

19 (a) (b)
(Signature of local registrar)

DEC 17 1941

Registered by Lester Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 1941, at 2.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/14 1941 to 12/14 1941 and that I last saw h[illegible] alive on 12/14 1941.

Immediate cause of death Hepatic Insufficiency — Duration

Due to Portal Cirrhosis

Due to

Other Conditions Pulm. Edema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Portal Cirrhosis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Rosen M. D.
Address Sinai Hospital Date signed 12/14/41

X

G16563 BC# BALTIMORE CITY HEALTH DEPARTMENT G16563

a61886 664672 CERTIFICATE OF DEATH 159 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1320 Nelwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Baby Boy Otten

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/6/46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 2 | hr. min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name William L Otten
FATHER 13. Birthplace Md
MOTHER 14. Maiden Name Ruth Clinedill
MOTHER 15. Birthplace N.J.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical Schoo DEC 16 1946
Location

18 (a) Funeral director Commissioner of Health
(b) Address

DEC 17 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 8 1946, at 7 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-6- 1946, to 12-18-1946, and that I last saw him alive on 12-8- 1946.

| Immediate cause of death | Duration |
|---|---|
| Prematurity | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Phillip Brace M. D.
Address Johns Hopkins Hosp. Date signed 12-9-46

VS 150

Birth Certificate

G16564 D-71934

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

G16561 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 911 E Madison St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Beckett

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Black | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-11-46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | 6 hr. min. |

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Donald Beckett
13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth ?
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical Sch DEC 16 1946
Location

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 17 1946 (Date rec'd by registrar) (b) Hunter Jean Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1946 at 5:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 Dec 1946 to 11 Dec 1946 and that I last saw her alive on 11 Dec 1946

| Immediate cause of death | Duration |
|---|---|
| Prematurity | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philip D Pearce M. D.
Address 13 Dec 1946 Date signed
Johns Hopkins Hospital

VS 150

G16565 BC# G58459

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 119a

G16565 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2326 Cambridge St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MELVIN MILLER 58459

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/21/46

8. AGE: Years | Months 2 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name William Miller
13. Birthplace ?

MOTHER 14. Maiden Name Elizabeth ?
15. Birthplace ?

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, removal) (b) Date buried DEC 16 1946
Johns Hopkins Medical Schools
(c) Cemetery or crematory
Location Commissioner of Health

18 (a) Funeral director
(b) Address DEC 17 1946

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 2 1946 at 9:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2 1946 to Dec 2 1946 and that I last saw h alive on Dec 2 1946.

| | Duration |
|---|---|
| Immediate cause of death Dehydration - marasmus | 48 hrs |
| Due to Diarrhea & vomiting | 48 hrs. |
| Due to Malnutrition | 1 month |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy: Dehydration

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. Ennis M.D.
Address Sinai Hosp Date signed Dec 6

VS 150

J. ENNIS, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46566

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

G46566
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 105 S. Bouldin Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 76
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 S. Bouldin Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: WILLIAM HENRY KRAMER

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Rosa Kramer
6 (c) If alive, give age 64 years
7. Birth date of deceased (mo., day, yr.) June 23, 1871
8. AGE: Years 75 | Months 5 | Days 22 | If less than one day ... hr. ... min.
9. Birthplace: Baltimore County (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business: Standard Oil Co.

FATHER
12. Name: George Kramer
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Elizabeth Thorne
15. Birthplace: Maryland

16 (a) Informant: Mrs. Rosa Kramer
(b) Address: 105 S. Bouldin Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-17-43 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

DEC 17 1946

VS-150

**MEDICAL CERTIFICATION** A. M.

20. DATE OF DEATH: Dec. 15 1946, at 2.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1946 to Dec 15 1946 and that I last saw h... alive on Dec 14 1946

Immediate cause of death: Cerebral Thrombosis Duration 1 yr
Antecedent Uraemia Duration 1 mo
Due to Chronic Nephritis Duration 5 yrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: J. M. Thomas M. D.
Address 913 Cathedral St Date signed 12/16/46

J. M. Thomas X

G46567

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1948

G46567 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 724 Brune Street
(c) Hospital or institution:

17

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 724 BRUNE Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

**3 (a) FULL NAME** CARRIE JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| FEMALE | Colored | Widow |

6 (b) Name of husband or wife GEORGE JOHNSON
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 16, 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 7 8 | 14 27 | hr. min. |

9. Birthplace CALVERT COUNTY, MARYLAND (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Julius Murry
13. Birthplace CALVERT COUNTY MARYLAND

MOTHER
14. Maiden Name Elizabeth GRAY
15. Birthplace MARYLAND

16 (a) Informant Myrtle JACKSON
(b) Address 724 BRUNE Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-17-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Pt
Location C. C. Co., Md

18 (a) Funeral director George G Tilson
(b) Address 1313 Bentman St

19 (a) (Signature of local registrar) (b) Registrar

DEC [illegible] Hunting for Mil

VS 2

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 13 1946, at 12:53 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-6 1946, to 12-13 1946, and that I last saw her alive on 12-13 1946

| Immediate cause of death | Duration |
|---|---|
| CARDIAC Failure | Several hrs. |
| Due to PNEUMONIA | 5 days |
| Due to Senility | over |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard H. Hunt #23 M. D.
Address 1607 W. Mulberry St Date signed 12/16/46

G46568

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 30E

G46568
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 118 North Bond Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Blanche Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 40 | | | hr. min. |

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ?
13. Birthplace Va

MOTHER
14. Maiden Name Annie Johnson
15. Birthplace Va.

16 (a) Informant Bernard Durrell
(b) Address 1403 E. Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County, Md.

18 (a) Funeral director Joseph B. Locke Jr.
(b) Address 3, 304 N. Central Ave

19 (a) DEC 17 1946 (Date rec'd by registrar) (b) Registrar

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** December 13, 1946, at 11 A. M.

**21.** I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Syphilitic heart disease

Due to

Other Conditions Obesity

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 12/13/46

VS 191

Huntington Williams, MD

G16569 BC# G64805

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH V 200 c

G16569
Registered No. 24747

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 420 Steade Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County B
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 420 Steade Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

**3 (a) FULL NAME** Baby Meachem

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | S |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/13/46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 0 | 0 | 3 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Edward Meachem
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Charlotte Gleacoe
15. Birthplace Martinsburg W. Va.

16 (a) Informant Edward Meachem
(b) Address 420 Steade Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (Year)
(c) Cemetery or Crematory
Location

18 (a) Funeral director
(b) Address

DEC 17 1946
(Date rec'd by registrar) Registrar

Johns Hopkins Medical Schoo DEC 16 1946
Commissioner of Health
Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15 1946, at 9:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12 1946, to Dec. 15 1946 and that I last saw him alive on Dec. 14 1946.

| Immediate cause of death | Duration |
|---|---|
| Undetermined. | |
| Due to — | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R B Ligon Jr M. D.
Address 501 Cherry Hill Rd. Date signed 12/15/46

VS 150

G46570

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

Registered No. G46570

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3931 Keswick Rd.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3931 Keswick Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Randall King

3 (b) If veteran, name the war: None

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Francis E. King

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 27 1862

8. AGE: Years 64 | Months 9 | Days 19 | If less than one day: hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Wm. D. Randall
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Isabella Jones
15. Birthplace Balto. Md.

16 (a) Informant Mr. J. C. King, Husband
(b) Address 3931 Keswick Rd. Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/46 (month) (day) (year)

(c) Cemetery or crematory Green Mt.
Location Balto. Md.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (E. F. MOWEN SUC.) 100 N. HOWARD AVENUE

19 (a) DEC 17 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 16 1946 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1946 to Dec 16 1946, and that I last saw him alive on Dec 15 1946.

Immediate cause of death: Bronchial Pneumonia — Duration: 2 days

Due to: Carcinoma of Right Breast — Duration: since June 1945

Due to: Carcinomatosis of Lungs,

Other conditions:

(Include pregnancy within 3 months of death)

Date of operation: Jan 1946

Major findings of operation: Radical removal of Right breast

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rob't Keyser M. D.
Address Westminster Md. Date signed 12/16/46

G16571

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 107

Registered No. G16571

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give name)
(d) Street No. 220 E Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Margaret D Perveil

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife William H. Perveil
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1872

8. AGE: Years 74 | Months 2 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation (None) At home

11. Industry or business

FATHER
12. Name Moses Hindes Powder
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Algeria V. Foose
15. Birthplace Baltimore, Md

16 (a) Informant Mrs Beryl D. Treadway
(b) Address Riggs Ave Serverna Pk, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/46 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md

18 (a) Funeral director H. H. Mears and Son
(b) Address 805 N. Calvert St.

19 (a) DEC 17 1946 (Date rec'd by registrar) Registrar

VS 151

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec 15th 1946, at 11:50 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to he death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Broncho-Pneumonia

Due to

Other Conditions Mal-nutrition

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J McGlade M.D. Medical Examiner
Date signed Dec 16-46

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16572

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 1937

G16572 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4233 Shamrock Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7d
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4233 Shamrock Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** May Welner Baird

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife James F. Baird

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29-1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 8 | 16 | hr. min. |

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Alonza Hubbard
13. Birthplace Md.

MOTHER
14. Maiden Name Margeret Fluhardy
15. Birthplace Md.

16 (a) Informant Carlton Baird
(b) Address 4233 Shamrock Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 17/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Co.
Location North Ave. & Gay St.

18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.

19 (a) DEC 17 1946 (Received by registrar) Registrar

Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/14 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/9 1946, to 12/14 1946, and that I last saw him alive on 12/14 1946.

| Immediate cause of death | Duration |
|---|---|
| Congestive Cardiac Failure | |
| Due to Arteriosclerotic | |
| Due to Cardio-Vascular Disease | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. J. Stevens M.D.
Address 3402 Erdman Date signed 12/16/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46573

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1939

Registered No. G46573

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution:
St. Joseph Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2909 Shirey Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles Frederick Gillespie SR.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| None | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of ~~husband~~ wife Alice E. Gillespie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 1 | 11 | hr. min. |

9. Birthplace Rossville, Md.
(Town, county, and state)
10. Usual Occupation Postman, Retired
11. Industry or business Balto. Post Office

FATHER
12. Name James M. Gillespie
13. Birthplace Unknown

MOTHER
14. Maiden Name Amelia Nayment
15. Birthplace Unknown

16 (a) Informant Mr. Charles F. Gillespie Jr.
(b) Address 611 Wyanok Ave.

17 (a) Burial (b) Date thereof 12/18/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~XXXXXX~~ Oaklawn
Location Balto. Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa Aves. Balto. 17, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 17 1946 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 16 1946 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1938 to Dec 16 1946
and that I last saw ~~him~~ her alive on Dec 9th 1946

Immediate cause of death Chronic Myocarditis — Duration 8 years
Due to
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Yes

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 5706 Harford Rd. Date signed 12/16/46

VS. 150 ×

G16574

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G16574

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 8/4
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4229 Euclid ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Mary Daily (ANN)
3 (b) If veteran, name war None
3 (c) Social Security Account No. None
4. Sex F W
5. Color or race W
6 (a) Single, married, widowed, or divorced. ✓ Single
6 (b) Name of husband or wife None
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 17, 1856
8. AGE: Years 90 | Months 5 | Days 29 | If less than one day hr. min.
9. Birthplace Staunton, Va.
(Town, county, and state)
10. Usual Occupation Retired Storekeeper
11. Industry or business
FATHER 12. Name John Daily
13. Birthplace Ireland
MOTHER 14. Maiden Name Ellen Ryan
15. Birthplace U. S. A.
16 (a) Informant Miss Hilda Kohlepp, Friend
(b) Address 4229 Euclid Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/46 (month) (day) (year)
(c) Cemetery New Cathedral
Location Balto. Md.
18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa Aves. Balto. 17, Md.
19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12-16 1946 at 1 30 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 6/17 1944 to 12/16 1944, and that I last saw her alive on 12/16 1946.

| | Duration |
|---|---|
| Immediate cause of death Acute Cardiac vascular Collapse | 24 hrs |
| Due to Acute pulmonary edema | 48 hrs |
| Due to | |
| Other Conditions Arteriosclerosis & Hypertension | 3 yrs. |

If there was operation, state (a) Disease for which performed (b) Date of operation
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address 33 W. Lafayette Ave. Date signed

DEC 17 1946

VS-150

TG16575

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

Registered No. G46575

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo. 11 da
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 S. Carey St. Balto 30
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Marie Dorsey

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | W | single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2, 1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | 3 | 14 | hr. min. |

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation store keeper
11. Industry or business

**FATHER**
12. Name Lawrence Dorsey
13. Birthplace Md.

**MOTHER**
14. Maiden Name Frances Hessler
15. Birthplace Md

16 (a) Informant hosp. record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 19/46 (month) (day) (year)
(c) Cemetery or crematory Mem. Gatherdale
Location Frizbriks Road

18 (a) Funeral director Thomas J. Kennedy
(b) Address Belmont and Hoffman St

DEC 17 1946 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12-16-46 1946 at 10 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20 1946 to Dec 15 1946 and that I last saw her alive on Dec 15, 1946

| Immediate cause of death | Duration |
|---|---|
| pulmonary edema | |
| Due to metastases from | |
| Due to carcinoma of breast | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James J. Gulack M. D.
Address Mercy Hosp. Date signed 12-16-46

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

046576

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1/168

Registered No. 046576

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 W. Fayette st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Judy Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1916

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 30 | | | hr. min. |

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery University Medical School DEC 17 1946
Location

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 17 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 12/4 1946, at 5 P. M.

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Strangulation

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-4-46 P. M.
(b) Where did injury occur? 1002 W. Fayette St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Manual strangulation

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12-5-46

G16577

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G16577

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use ink.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1120 Hanover St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 Hanover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Andrew Rocke

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | | | hr. min. |

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or University Medical School DEC 17 1946
Location

18 (a) Funeral director
(b) Address

19 (a) DEC 17 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

Commissioner of Health

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11/29 1946, at 8:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C.V. disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Farbenski M.D.
Medical Examiner.
Date signed 11/29/46

VS 181

G16578

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

166

G16578

Registered No.

write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Va. (b) County
(c) City or town Portsmouth
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Joseph Edward White

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1916

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 30 | | | hr. min. |

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory University Medical School DEC 17 1946
Location

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 17 1946 (Date received by registrar) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 7, 1946 at 12.10 a.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Bullet wounds of aorta, heart & lung.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-7-46 12 a. M.
(b) Where did injury occur? Fremont & Lemon Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Firearms — revolver

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 12-7-46

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16579

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 122a

G16579 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 Eastern Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Francesa Weber

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | married |

6 (b) Name of husband or wife [redacted] Wm.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-4-1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 9 | 10 | hr. min. |

9. Birthplace Europe ? (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Joseph Racata
13. Birthplace Europe ?

MOTHER 14. Maiden Name ? ?
15. Birthplace ?

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-46 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Baltimore City

18 (a) Funeral director Wm. J. Fiddes Sons
(b) Address 2007 Eastern Ave

19 (a) Dec 17 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 1946, at 5.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 13 1946 to Dec. 14 1946, and that I last saw h[illegible] alive on Dec. 14 1946.

| | Duration |
|---|---|
| Immediate cause of death Intestinal obstruction | 5 Days |
| Due to strangulated umbilical hernia | 5 days |
| Due to | |
| Other Conditions Dehydration | |

(Include pregnancy within 3 months of death)
Date of operation 12/14/46
Major findings of operation: Strangulated umbilical hernia
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard D. Bush
Address Johns Hopkins Hosp. Date signed 14 Dec 46

VS 150

X

G16580

G16580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2415 Pelham Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 Eastern ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Fialkowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-2-1878

8. AGE: Years 68 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Funeral Director

11. Industry or business

FATHER
12. Name Jacob Fialkowski
13. Birthplace Poland

MOTHER
14. Maiden Name Victoria Potocki
15. Birthplace Poland

16 (a) Informant Wm. S. Fialkowski
(b) Address 2007 Eastern ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-19-46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto Co

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern ave

19 (a) DEC 17 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16 1946, at 6:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1942 to Dec 16 1946, and that I last saw h- alive on Dec 16 1946.

| Immediate cause of death | Duration |
|---|---|
| Uremia | 3 days |
| Due to Arterio-Sclerotic Hypertensive Myocardial Disease | 4 yrs. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Quidlen M. D.
Address 201 E. Fayette St Date signed 12/16/46

X

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46581

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 183a

Registered No. G46581

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1509 N. Carey st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1509 N. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Carrie Va. Bishop

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Chas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/17/1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 54 | 8 | 28 | hr. min. |

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

**FATHER**
12. Name Robert Taylor
13. Birthplace Md

**MOTHER**
14. Maiden Name Campbella Johnson
15. Birthplace Md.

16 (a) Informant Pashie Bishop
(b) Address 1509 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. S. Nelson
(b) Address 1303 Pressman St

19 (a) DEC 17 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/15 1946, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/20 1946 to 12/15 1946, and that I last saw her alive on 12/15 1946.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | |
| Due to Paralysis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Burkett M. D.
Address 2129 N. Fulton Ave Date signed 12/16/46

VS 180

G46582

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 130E

Registered No. G46582

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1126 Parrish Alley
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

**3 (a) FULL NAME** ROBERT HALLEY (Holly)

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| W. W. I | Unknown |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | widowed Single |

6 (b) Name of husband or wife Annie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 49 | | | hr. min. |

9. Birthplace St Mary's Co. Md
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unable
15. Birthplace

16 (a) Informant Eleanore Hall
(b) Address 416 Wilson St

17 (a) Burial (b) Date thereof 12/18/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto-Nat
Location Md

18 (a) Funeral director Geo. A. Nelson
(b) Address 1303 Pressman St

19 (a) DEC 17 1946 (b) Huntington Mills Md.
(Date rec'd by registrar) (Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 15, 1946, at 11 a.m. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Syphilitic heart disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home or farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature George H. Merrill M.D.
Medical Examiner.
Date signed 12/16/46

VS 191

Correct cause is especially important. Physicians: please write the causes of death clearly and legibly.

G16583 G16583

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 198

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 954 Forrest St.
(c) Hospital or institution: Maryland Penitentiary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr 26
(e) Length of stay in Baltimore (yrs., mos., or days) ??

**2. USUAL RESIDENCE OF DECEASED:**
(a) State N. Car. (b) County
(c) City or town Wilson
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 63 - Route 4
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Jack Lester Barnes

3 (b) If veteran, name war ??

3 (c) Social Security Account No. 228-38 06 86

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/11/1921

8. AGE: Years 25 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace Wilson, N. Car.
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Aaron Barnes
13. Birthplace Wilson, N. Car.

MOTHER
14. Maiden Name Lillian Reed
15. Birthplace Wilson, N. Car.

16 (a) Informant L. C. Hemby
(b) Address Fountain N. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/46 (month) (day) (year)

(c) Cemetery or crematory Wilson, N. C.
Location N. C.

18 (a) Funeral director Guy H. Nelson
(b) Address 1303 Parsonage St.

DEC 17 1946 (b) Huntington for Williams, Md.
(Registered by Registrar) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 13 1946 at 12:13 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 6 1945 to Dec. 13 1946, and that I last saw him alive on Dec. 13 1946.

| Immediate cause of death | Duration |
|---|---|
| Dislocation of 5th cervical vertebra | |
| Due to Execution by hanging | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John F. Anthony M. D.
Address Maryland Penitentiary Date signed 12-13-46

G16581

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G16581 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2920 McElderry St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 54yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2920 McElderry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Onofrio Cimino

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Santina R.Cimino
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27,1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 4 | 17 | hr. min. |

9. Birthplace Itlay
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Salvatore Cimino
13. Birthplace Itlay

MOTHER
14. Maiden Name --
15. Birthplace Itlay

16 (a) Informant Joseph S.Cimino
(b) Address 2100 Orleans St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec.18/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto., Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

19 (a) (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

**MEDICAL CERTIFICATION** A.

20. DATE OF DEATH December 14 1946, at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 25, 1946, to Dec. 14, 1946 and that I last saw him alive on Sept. 15, 1946.

| Immediate cause of death | Duration |
|---|---|
| Congestive Heart Failure | 1/2 hour |
| Due to Arteriasclerosis | Unknown |
| Chronic Myocarditis | Unknown |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Philip Henry Sons
Address 2942 E. Fayette St. Date signed 12/18/46

X

D46585

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G46585 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 748 W Fayette St
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 748 W Fayette St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ira G. Bowman

3 (b) If veteran, name war —
3 (c) Social Security Account No. ?

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Unknown
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) about 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| about 73 | | | hr. min. |

9. Birthplace New York (State)
(Town, county, and state)
10. Usual Occupation Painter
11. Industry or business —

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Geo. F. Bayer Jr
(b) Address 457 Hollins St

17 (a) Burial (b) Date thereof 12/17/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Rockland Md

18 (a) Funeral director Geo F Bayer Jr
(b) Address 457 Hollins St

19 (c) 12 17 1946
(Date rec'd by registrar) Washington Williams, M. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15 1946, at 7.A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 25 1946, to Dec 15 1946, and that I last saw him alive on Dec. 14 1946;

Immediate cause of death Myocarditis — Duration ?

Due to Arteriosclerosis — ?

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Carl A Rosking M. D.
Address 132 E. Lombard St Date signed 12/15/46

VS 150

X

G16586

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G16586

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 302 E. Randall Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 302 E. Randall Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William H. Franklin

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife Anna M. Hohman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 2 | 26 | hr. min. |

9. Birthplace Carroll County, Md.
(Town, county, and state)
10. Usual Occupation Steam Fitter
11. Industry or business Bethlehem Shipyard

FATHER
12. Name Samuel Franklin
13. Birthplace Md.

MOTHER
14. Maiden Name Serah E. ?
15. Birthplace Md.

16 (a) Informant Family
(b) Address 302 E. Randall Street

17 (a) B (Burial, cremation, or removal) (b) Date thereof 12/18/46 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Edmondson Ave.

18 (a) Funeral director Samuel L. McCurley
(b) Address 120 E. Fort Ave.

19 (a) Date received by registrar Huntington Williams M.D.
DEC 17 1946

VS 180

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 15 1946, at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946, to Dec 1946, and that I last saw h[illegible] alive on Dec 14 1946.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 12 hrs |
| Due to Arteriosclerosis | 2? |
| Due to Diabetes Mellitus | 14 years |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter Kohn M.D.
M. D.
Address 1026 Fort Ave. Date signed 12/16/46

832

G16587

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 194a

G16587 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Dobbs
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Beltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 38 S. Hanover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Walter L. Hendricks

3 (b) If veteran, name war —
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1901

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 45 | | | hr. min. |

9. Birthplace With Co, Va
(Town, county, and state)
10. Usual Occupation Goodwill Ind.
11. Industry or business

FATHER
12. Name Rufus Va
13. Birthplace

MOTHER
14. Maiden Name Mollie Coulson
15. Birthplace Mt R. Va

16 (a) Informant Mr R. L. Coulson
(b) Address 3321 Biloxdale Ave

17 (a) Burial (b) Date thereof 12/17/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Pulaski Va

18 (a) Funeral director L. Heemann & Son
(b) Address 32 S. Broadway

19 (a) (Date received by Registrar) (b) Huntington Williamsport, Md.

DEC 17 1946

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/14 1946, at 4:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature C. J. Lubinski M.D.
Medical Examiner.
Date signed 12/14/46

G16588

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1946

Registered No. G16588

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1434 W. Balto St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** James Cooney

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 1873

8. AGE: Years 73 Months 11 Days 29 If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and State)

10. Usual Occupation Elevator Operator
11. Industry or business

FATHER
12. Name Michael Cooney
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary E. McGrogan
15. Birthplace Baltimore Md.

16 (a) Informant James Cooney
(b) Address 1434 W. Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Catholic
Location 4300 Old Frederick Road

18 (a) Funeral director John J. Cooney & Son
(b) Address 90-92 Stollen St

19 (a) (Signature of local registrar) (b) Dec 17 1946 Huntington Williams Registrar

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec 16 1946 at 2:45 PM

**21.** I certify that death occurred on the date above stated; that I attended deceased from 12-13 1946 to 12-16 1946, and that I last saw him alive on 12-16 1946.

Immediate cause of death Acute Cardiac Dilatation — Duration —
Due to Arteriosclerotic Cardiovascular Disease
Due to
Other Conditions Generalized Anemia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. K. Briggs M.D.
Address 1434 W. Balto St Date signed 12-16-46

X

G16589

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G16589 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 805 Stoll St.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 805 Stoll St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Leonora Muncy

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | married |

6 (b) Name of husband or wife Munroe Muncy
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) November 19, 1908

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 38 | -- | 26 | hr. min. |

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name James Rabey
13. Birthplace N. C.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Munroe Muncy
(b) Address 805 Stoll St., Brooklyn, Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John C. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) DEC 17 1946 (Date rec'd by registrar) Registrar
Hunting for Milligan, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 15 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1946, to Dec. 15 1946, and that I last saw her alive on Dec. 14 1946

| Immediate cause of death | Duration |
|---|---|
| General Carcinomatosis | 1 yr. |
| Due to Carcinoma of Uterus | 2 yrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation July 45
Major findings of operation: Biopsy - Carcinoma of uterus
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 1901 Eutaw Place Date signed 12/17/46

G16590 — BALTIMORE CITY HEALTH DEPARTMENT — G16590

Reg. No. 106562

# CERTIFICATE OF DEATH 130

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 632 Perkins Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Elmer Sewell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Sept

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec/4th. 1904

8. AGE: Years 42 | Months 0 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Decorater

11. Industry or business

FATHER
12. Name Joseph Sewell
13. Birthplace Maryland

MOTHER
14. Maiden Name Jane Sewell
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-512 N. Carrollton Ave

19 (a) DEC 17 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14th 1946, at 11.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 2/1946 to Dec 14th 1946 and that I last saw him alive on Dec/14 1946.

Immediate cause of death: Pulmonary Tuberculosis — Duration: Oct 1946

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same, with hemorrhage

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. E. Bird M. D.
Address Balto City Hosps Date signed 12-16-46

correct age is especially important. Physicians: please write the

VS 150

G16591 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G16591

In. 106843

# CERTIFICATE OF DEATH 467

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2614 Woodbrook Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/8/871

8. AGE: Years 75? Months ?4 Days ?6 If less than one day hr. min.

9. Birthplace Chas Co. Md (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave ( records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/46 (month) (day) (year)

(c) Cemetery or crematory St Peters Cemetery

Location Balto Md

18 (a) Funeral director Chas. L. Thorpe

(b) Address 510-12 Cathedral St.

19 (a) DEC 17 1946 (Date rec'd by registrar) (b) Huntington Md (Signature, Registrar)

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH December 14th 1946, at 11.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec/14th 1946 to Dec/14th 1946 and that I last saw him alive on Dec 14th 1946

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure | |
| Due to Cardiovascular decompensation | |
| Due to arteriosclerotic cardiovascular disease. | |
| Other Conditions Carcinoma of rectum with metastases to liver | |

(Include pregnancy within 3 months of death)

Date of operation 0

Major findings of operation:

of autopsy 12/18/46 Carcinoma

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. A. Gibbs M. D.

Address Baltimore City Hosps. Date signed 12/18/46

VS 150

correct age is especially important. Physicians: please

G16592

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G16592

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1926 Gough Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1926 Gough Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Wladyslaw Brzezinski

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Waleria
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October ?, 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 2 | | hr. min. |

9. Birthplace Bruchow, Poland
(Town, county, and state)
10. Usual Occupation Bricklayer
11. Industry or business

FATHER
12. Name John Brzezinski
13. Birthplace Bruchow, Poland

MOTHER
14. Maiden Name Julia Gilczynska
15. Birthplace Bruchow, Poland

16 (a) Informant Mr. Joseph Brzezinski
(b) Address 1926 Gough Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location German Hill Road

18 (a) Funeral director M. F. Sadowski & Son
(b) Address 1808 Eastern Avenue

19 (a) (Date rec'd by registrar) DEC 17 1946 (b) Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 1946, at 7.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 18 1946, to Dec 14 1946, and that I last saw h alive on 19

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Oedema | 1 |
| Due to Myocardial Degeneration | 1 yr |
| Due to Arterio-Sclerosis | 10 yrs |
| Other Conditions Cystitis | 6 mos |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury
23. Signature A. F. Rees M. D.
Address 24 S. Bury Date signed Dec. 16/46

X

G16593
CHK-106054

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G16593

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 3- 5
(e) Length of stay in Baltimore (yrs., mos., or days) 42- 9- 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 Colvin Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Genovese

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11-1904

8. AGE: Years 42 | Months 9 | Days 5 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Anthony Genovese
13. Birthplace Italy

MOTHER
14. Maiden Name Lena Cururi
15. Birthplace Italy

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 20 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Belair Road

18 (a) Funeral director Joseph Farace Inc
(b) Address 2013 Monument Ave

19 DEC 17 1946 (Date rec'd by registrar) (b) Huntington Willis, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 1946, at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1946 to Dec. 16 1946, and that I last saw him alive on Dec. 16 1946.

Immediate cause of death: Uremia — Duration

Due to Hypertensive Heart Disease

Due to Pyelonephritis, Chronic

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy yes

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. C. Rahmer Jr. M. D.
Address Balt. City Date signed 12/16/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G16594

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

G16594 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 901 Bayard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) yr
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Bayard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Paul M. Stiegmann

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife Tillie Stiegmann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3- 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 5 | 12 | hr. min. |

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business Retired

FATHER 12. Name Frederick K. D. Stiegmann
FATHER 13. Birthplace Germany
MOTHER 14. Maiden Name Caroline Pundt
MOTHER 15. Birthplace Germany

16 (a) Informant Mrs Tillie Stiegmann
(b) Address 901 Bayard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-1946 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St

19 (a) DEC 17 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 15 - 1946, at 7:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 2 1946, to Dec. 15 1946, and that I last saw h.. alive on Dec. 14 1946.

| Immediate cause of death | Duration |
|---|---|
| Oedema of Lung | 1/2 hr |
| Due to Apoplexy | 14 hrs |
| Due to Hypertension | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation —
of autopsy —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury

23. Signature H. B. Myers M. D.
Address 116 Cathedral St Date signed 12-16-46

VS 150

PRINT IN WHITE LETTERS, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16595

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48a

G16595 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 9h. Bond Lt (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Piney Mills

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 4-18-01
8. AGE: Years 45 Months 7 Days 27 If less than one day hr. min.
9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Wm Luelles -
13. Birthplace N. C. -

MOTHER
14. Maiden Name Andora Wuggins
15. Birthplace N. C. -

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 19. 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calv. Cem
Location Brooklyn Md
18 (a) Funeral director Elmer S. Wilson
(b) Address 1519 Carlton St
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION** 30

20. DATE OF DEATH Dec. 15 1946 at 11 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 25 1946 to Dec 15 1946 and that I last saw her alive on Dec. 15 1946.

Immediate cause of death: Intestinal Obstructions — Duration: 3 weeks
Due to: Primary Carcinoma - 2 yrs
stated to pertain, Diaphragm
Due to
Other Conditions: Syphilis, Laryngeal Paralysis, partial 10yr
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Otherwise negative findings

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Yates Long M. D.
Address The John Hopkins Hosp Date signed 12/15/46

VS 150

PRINTING WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16596 BC# BALTIMORE CITY HEALTH DEPARTMENT G16596

Registered No. 29237

# CERTIFICATE OF DEATH 54a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 42 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 mos.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Louise Alison Ayres
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Single |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1945

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 1 | 4 | 19 | hr. min. |

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation child
11. Industry or business —

FATHER
12. Name Billy James Ayres
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Joanne Delo
15. Birthplace Massachusetts

16 (a) Informant Mother
(b) Address 14 Allegheny Ave, Towson, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 18, 1946 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Cem
Location Towson, Md.
18 (a) Funeral director John Burns' Sons
(b) Address Towson, Md.
19 (a) 1946 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 16 1946, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-5 1946 to 12-16 1946, and that I last saw her alive on 12-16 1946.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | 2 days |
| Due to Brain Tumor | 2 mos |
| Due to | prev |
| Other Conditions Paralysis Rt. 10, 11 & 12 cranial nerves. (Include pregnancy within 3 months of death) | |
| Date of operation | |
| Major findings of operation: | |
| of autopsy Right posterior cerebellar tumor | |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Katherine Sprunt M. D.
Address Union Memorial Hospital Date signed 12-16-46

X

G46597 G46597

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street city
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr.
(e) Length of stay in Baltimore (yrs., mos., or days) 87yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** Anna Eckelton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Joseph Eckelton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/1859

8. AGE: Years: 87 | Months: 11 | Days: | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Housework

11. Industry or business

FATHER
12. Name: John Shaeffer
13. Birthplace: Germany

MOTHER
14. Maiden Name: Therese Schoate
15. Birthplace: Germany

16 (a) Informant: Little Sisters of the Poor
(b) Address: 1200 Valley St. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 18, 1946 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: Baltimore

18 (a) Funeral director: Peter Wiedefeld
(b) Address: 900 East Biddle St

19 (a) 1946 (Date rec'd by registrar) (b) Langston Williams, Registrar

VS 2

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec 16 — 1946 at 5:45 PM

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec-1— 1946, to Dec 16— 1946, and that I last saw her alive on Dec 16— 1946.

| Immediate cause of death | Duration |
|---|---|
| Edema of Lungs — | 2 days |
| Due to | |
| Due to Chronic Bronchitis | 14 days |
| Other Conditions Chronic Myocarditis | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E North Ave Date signed Dec 17-46

Please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

In Office G16598

G16598

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G16598

107

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1014 N. Wolfe st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 N. Wolfe st
(If rural give location)
(e) Citizen of foreign country? (Yes or No) Y
If yes, name country

3 (a) FULL NAME Lottie Gordon

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age* years

7. Birth date of deceased (mo., day, yr.) 12-7-1887

8. AGE: Years 59 | Months - | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Domestic.

11. Industry or business

FATHER 12. Name Henson Edwards

13. Birthplace Va.

MOTHER 14. Maiden Name Susie Perkins

15. Birthplace Va.

16 (a) Informant Mary Lee

(b) Address 1014 N. Wolfe st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/46 (Month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantly ave

19 (a) 12/17 1946 Huntington Williams, Registrar (Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12-13-46 at 12.34 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 12/7 1946 to 12/13 1946 and that I last saw her alive on 12/13 1946.

Immediate cause of death: (a) Bronchial Pneumonia — Duration 12 dys

Due to: (b) Asthma

Due to: (c) Exposure

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. R. Blake M. D.

Address 1327 N. Eutaw Date signed 12-17-46

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16599

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 B

G16599 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo 15 ds
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. East Court Apt. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Elizabeth Thompson

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Mr Curtis Thompson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25 1858

8. AGE: Years 88 | Months 4 | Days 21 | If less than one day hr. min.

9. Birthplace Philadelphia (Town, county, and state)

10. Usual Occupation Housemaker

11. Industry or business Housework

FATHER
12. Name John M Charles Baker.
13. Birthplace Pa.

MOTHER
14. Maiden Name Miss Lea.
15. Birthplace Pa.

16 (a) Informant Mr. R L Thompson.
(b) Address East Court St.

17 (a) Cremation (b) Date thereof Dec 18 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount Cem
Location Balto Md

18 (a) Funeral director Henry W Jenkins & Sons
(b) Address Mc Culloh & Orchard Sts

DEC 18 1946 (b) —
(Date rec'd by registrar) Registrar

Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1946, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 16 1946 to Dec 16 1946, and that I last saw h alive on Dec 16 1946.

| Immediate cause of death | Duration |
|---|---|
| Peritonitis + general. | 4 days |
| Due to Perforated gastric ulcer of gastric curvature. | 4 days |
| Due to Adenocarcinoma of stomach | 6 mos. |
| Other Conditions Arteriosclerosis general | 20 yrs. |

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: autopsy — perforated gastric ulcer, adenocarcinoma

of autopsy: yes

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature David Barlow M. D.
Address Church Home & Hosp. Date signed Dec 17, 46

G16609

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

Registered No. (illegible)609

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5603 Carter Avenue
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5603 Carter Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie A. Norris

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Howard M

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 15-1875

8. AGE: Years 71 | Months 1 | Days 2 | If less than one day hr. min.

9. Birthplace Pennsylvania
(Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Jenfield
13. Birthplace Unknown

MOTHER
14. Maiden Name Martha H
15. Birthplace Unknown

16 (a) Informant Howard M. Norris
(b) Address 5603 Carter Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 20 46 (month) (day) (year)
(c) Cemetery or crematory Loraine Park
Location Baltimore

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

19 (a) Dec 18 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 1946, at 8:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 13 1946 to Dec. 17 1946 and that I last saw h[illegible] alive on Dec 16 1946

| Immediate cause of death | Duration |
|---|---|
| Hemorrhage cerebral | 4 days |
| Due to Hypertension | 5 yrs. |
| Due to | |
| Other Conditions Diabetes | 5 years |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo G. Mann M. D.
Address 716 Eutaw St Date signed Dec 20 46

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

830

G16601

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 52 B

Registered No. G16601

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Howard & Madison Sts.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 77 d
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 137 South Hilton Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Thomas L. Orndorff

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Lillie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 5 | 25 | hr. min. |

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business B & O R R

FATHER 12. Name Milton Orndorf

13. Birthplace Md

MOTHER 14. Maiden Name Susan Landerman

15. Birthplace Md

16 (a) Informant Victoria Scott

(b) Address 137 S Hilton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/46 (month) (day) (year)

(c) Cemetery or crematory Confidence

Location Confidence Md

18 (a) Funeral director Milton Coblentz

(b) Address 1224 Poul St

19 (a) (Date rec'd by Registrar) (b) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December, 17 1946, at 5:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1946, to Dec. 17 1946, and that I last saw him alive on Dec. 17 1946.

| Immediate cause of death | Duration |
|---|---|
| uremia | |
| Due to carcinoma of the bladder | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation 11/2/46, 12/8/46, 12/15/46

Major findings of operation: Carcinoma of bladder

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John E Miller M. D.

Address Maryland Gen'l Hosp. Date signed 12/17/46

Huntington Williams, M.D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16602

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

Registered No. G16602

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3527 Dennison Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-3
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 Ruxton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hyman Baddock

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | W |

6 (b) Name of husband or wife Bertha
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Wm. Baddock
(b) Address 4032 Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-46 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Phil Rd & Biddle Lane

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 (a) (b)
(Date received by Registrar) Registrar

DEC 19 1946

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/17/46 19.. at 12 16 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 19 35 to Dec 16 1946 and that I last saw him alive on 12-16-1946

| Immediate cause of death | Duration |
|---|---|
| myocardial insufficiency | 6 yrs |
| Due to Hypertension | 15 yrs |
| Due to Diabetes mellitus | 20 yrs |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 6726 Dutton Rd Date signed Dec 17 46

X

G16603

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. G16603

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 6522 Fait Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. Md. (If outside city or town limits, write RURAL and give town) 5
(d) Street No. 6522 Fait Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anna M. Willkie

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Bernard G. Willkie | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1867

8. AGE: Years 79 | Months 2 | Days 1 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Fredk. Wetzel
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Wise
15. Birthplace Germany

16 (a) Informant Henry Willkie
(b) Address 6522 Fait Ave.

17 (a) Parkwood (Burial, cremation, or removal) (b) Date thereof 12 20 46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Langdon Stewart Home
(b) Address 9401 Belair Rd.

19 (a) (Date received by registrar) DEC 18 1946 (b) Burlington for Wilkins, M.D.

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec. 17th 1946, at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-28 1946 to 12-17 1946, and that I last saw h[illegible] alive on 12/17 1946

Immediate cause of death Cerebral Hemorrhage — Duration 6 hrs.
Due to arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: no

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James F. White M. D.
Address 7601 Eastern Ave Date signed 12/17/46
Baltimore 24, Md.

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16604

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46a

G16604 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1914 Casadel ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1914 Casadel ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Korciauskas
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-07-6339

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Eugenia J. Karciauskas
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Not know
8. AGE: Years 56 | Months | Days | If less than one day hr. min.
9. Birthplace Lithuanian (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER 12. Name ? Kozciauskas
15. Birthplace Lithuanian
MOTHER 14. Maiden Name Not know
15. Birthplace Lithuanian

16 (a) Informant Mrs Eugenia J. Karciauskas
(b) Address 1914 Casadel Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-46 (month) (day) (year)
(c) Cemetery or crematory Mesdowridge Memorial - Walter Blvd
Location Long Green Pike
18 (a) Funeral director John J. Grefiavage
(b) Address 423 N. Paca St
19 (Signature) Registrar
DEC 18 1946 (Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14 1946, at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from August 16 1946 to 12/14/46 19, and that I last saw him alive on 12/14/46 19

Immediate cause of death: Cerebral Thrombosis — Duration: 12 hrs
Due to: Metastases from Squamous Ca esophagus — Unknown
Due to:
Other Conditions: Secondary Anemia Malnutrition
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature D Mendelis
Address 651 N. Pentalou St. Date signed 12/14/46

VS 150

X

Please write or print plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G16605

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1/13B

G16605 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2019 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** [redacted] HEALEY VINCENT HEALEY

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| World War II | ? |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife: none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | | | hr. min. |

9. Birthplace Avoca, Pa. (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business

FATHER
12. Name James Healey
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Daugherty
15. Birthplace Ireland

16 (a) Informant A. F. O. Malley F. D.
(b) Address Avoca, Pa.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/18/46 (month) (day) (year)
(c) Cemetery or crematory ?
Location Avoca, Pa.

18 (a) Funeral director Wm. J. TICKNER & SONS INC.
(b) Address North & Pa Aves. Balto. 17, Md.

19 (a) (Date received by registrar) (b) Registrar

DEC 18 1946

V3.1M

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 12-16- 1946, at 1 P. M.

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary Tuberculosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12/16/46

G16606

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G16606 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Road
(c) Hospital or institution: Ashburton Nursing Home. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3520 Hilton Road. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** SADIE SCHLOSS WEINMAN.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Joseph Weinman.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1866.

8. AGE: Years 80 | Months 2 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Schloss,
13. Birthplace Germany.

MOTHER
14. Maiden Name Bertha Kahn,
15. Birthplace Germany.

16 (a) Informant Mr. Irvin Schloss,
(b) Address 2452 Eutaw Place.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12/18/46. (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Balto. Md.

18 (a) Funeral director Harris Sonneborn Sons
(b) Address 1902 Eutaw Place.

19 (a) (Name of registrar) (b) Registered

DEC 18 1946

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 16 1946, at 8.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Dec. 16, 1946, and that I last saw h[illegible] alive on Dec. 15, 1946.

Immediate cause of death: Myocardial Insufficiency — Duration: 1 week
Due to: Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sidney L. Levy, M.D.
Address 2452 Eutaw Place Date signed 12/18/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Edward Milan
682 Washington Blvd.

G16607

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V/31a

Registered No. G16607

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5411 Mayview Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5411 Mayview Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agata M. Orentas (ORNATAS)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife George Orantas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1877

8. AGE: Years 69 | Months 2 | Days | If less than one day: hr. min.

9. Birthplace Lithuania
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name ? Horant
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Anthony J. Horant
(b) Address 5411 Mayview Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 19 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 Dec 1946, at 9:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1942 to 16 Dec 1946 and that I last saw h. alive on 16 Dec 1946.

Immediate cause of death Arteriosclerotic Cardio-Vascular Renal Disease — Duration 4 YR

Due to Arteriosclerosis — 1 YR.?

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: —
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward J. Milan M.D.

Address 682 Washington Blvd Date signed 17 Dec 46

X

REMARKS WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16608

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1946

G16608 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 424 N. Green st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 424 N. Green St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Minker

3 (b) If veteran, name war W
3 (c) Social Security Account No. NONE

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

| 8. AGE Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | | | hr. min. |

9. Birthplace (Town, county, and state)
10. Usual Occupation Iron Worker
11. Industry or business

FATHER
12. Name (Unknown) Minker
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace

16 (a) Informant Marie M. Frazier
(b) Address 424 N. Green St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/46 (month) (day) (year)
(c) Cemetery or crematory Balto
Location " Md

18 (a) Funeral director William Cook Inc.
(b) Address 127 S. Paul St.

19 (a) (Date rec'd by registrar) (b) Huntington Hilliard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1946 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1946 to Dec 16 1946 and that I last saw h.e. alive on Dec 15 1946

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Oedema | 2 days |
| Due to Myocardial infarct | ? |
| Due to Arterio-sclerosis | ? |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank Lawrason M. D.
Address 1004 Liberty Hgts Date signed 12/17/46

VS-180 DEC 18 1946

X

Please write in ink or typewrite. Be careful to give correct age in especially important. Physicians: please write the causes of death clearly and legibly.

G16609

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 58E

Registered No. G16609

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3205 Dillon Street.,
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3205 Dillon Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK J. Bauernschub

3 (b) If veteran, name war: no
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Gloria A. (Nee Sauer)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 11, 1922

8. AGE: Years 24 | Months 3 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation 3rd Service Command
11. Industry or business

FATHER
12. Name Peter Bauerschub
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Henretta Archer (deceased)
15. Birthplace Baltimore, Md.

16 (a) Informant William Bauernschub
(b) Address 3308 O'Donell Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave.

18 (a) Funeral director Charles E. Schimunek.
(b) Address 2601-03 E. Madison St.

19 (a) (b)

VS 150

**MEDICAL CERTIFICATION** P.

20. DATE OF DEATH 15 December 1946, at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1946 to Dec. 15 1946 and that I last saw h[illegible] alive on Dec. 15 1946

Immediate cause of death: Subacute Bacterial Endocarditis — Duration: 2 mos.
Due to: acute Pleurisy Exud 3 mos
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature
Address 1007 E. Baltimore Date signed 12/17/46

Dec 18 1946 Registered in Washington Office of Vital Statistics

G16610

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G16610

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2743 Chesterfield Ave., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARGARET E. GANGLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Jacob (deceased)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 6, 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 10 | 10 | hr. min. |

9. Birthplace Hungary (Town, county, and state)
10. Usual Occupation housewife at home
11. Industry or business

FATHER
12. Name John Loch
13. Birthplace Hungary

MOTHER
14. Maiden Name Unknown
15. Birthplace Hungary

16 (a) Informant M. Elizabeth Gangler (daughter)
(b) Address 2743 Chesterfield Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross (Brooklyn)
Location Annapolis Blvd.

18 (a) Funeral director Charles E. Schimunek.
(b) Address 2001-05 E. Madison St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

DEC 19 1946

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/16 1946, at 6 15/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/16 1946 to 12/16 1946 and that I last saw her alive on 12/16 1946

Immediate cause of death Acut. Coron. art. occlusion & infarction — Duration 4 hours

Due to Hypertensive Cardio Vascular disease — Duration 7

Due to Arterio sclerotic Cardio-vascular disease — Duration 7

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roger L Brown M.D.
Address Sinai Hosp Date signed 12/16/46

VS 150

X

*Please write plainly, with unfading ink. Entry must be complete and correct as to every item; if cause of death is certainly stated, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16611

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 92B

G16611 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1609 E. Monument
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 E. Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs Jane Mumford

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Colored | Widow |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

| 8. AGE: Years | Months | Days | If less than one day hr. | min. |
|---|---|---|---|---|
| 68 | | | | |

9. Birthplace Dorchester Co., Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

| | |
|---|---|
| FATHER | 12. Name Samuel Conrad |
| | 13. Birthplace Dorchester Co Md |
| MOTHER | 14. Maiden Name Margrett Thomas |
| | 15. Birthplace Dorchester Co, Md |

16 (a) Informant Mrs Pearl Henderson
(b) Address 1609 E. Monument

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 21-19 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A. A. Co. Md.

18 (a) Funeral director Robt. F. Williams
(b) Address 1515 McElderry St

19 (a) (Date rec'd by Local Registrar) (b) Huntington, Williamsport, Md.

DEC 18 1946

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1946, at 5 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 13 1946 to Dec 16 1946, and that I last saw h[illegible] alive on Dec 16 1946

Immediate cause of death Mitral Insufficiency — Duration

Due to

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Fisher M.D.
Address 1609 E. Monument Date signed Dec 17 1946

X

Please fill in all items, if unknown, write "unknown." Do not abbreviate. Use ink and write the cause of death clearly and legibly. Physicians: please correct age is especially important.

G16612

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G16612

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 West Lexington (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** NOAH CHAPMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or div. Married

6 (b) Name of husband or wife Martha Chapman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1885

8. AGE: Years 61 | Months 1 | Days 22 | If less than one day hr. min.

9. Birthplace Pecks Co. N.C (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Nathan Chapman

13. Birthplace Pecks Co. N.C

MOTHER 14. Maiden Name Sabrye Bristo

15. Birthplace Pecks Co. N.C

16 (a) Informant Martha Chapman

(b) Address 1005 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 18, 1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem

Location

18 (a) Funeral director Mrs Kate R. Williams

(b) Address 922 N. Edmondson Ave

19 (a) DEC 18 1946 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS-101

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 12/14/46 19 , at 9:40 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Dawson M.D. Medical Examiner.
Date signed 12/14/46

X

G46613

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46a

Registered No. G46613

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3809 Belle Ave.
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-10
(e) Length of stay in Baltimore (yrs., mos., or days) 4½ yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3809 Belle Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? 20 yrs. years

**3 (a) FULL NAME** Joseph Schwab

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | widowed |

6 (b) Name of husband or wife Mary Stoltzenberger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 7 | 6 | hr. min. |

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name unknown
13. Birthplace Germany

MOTHER
14. Maiden Name unknown
15. Birthplace Germany

16 (a) Informant Mrs. Mary Biser
(b) Address 3809 Belle Ave.

17 (a) Burial (b) Date thereof 12/21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Pittsburg, Pa.

18 (a) Funeral director Mannion & Daly Inc
(b) Address 1900 Eutaw Place

19 (a) DEC 18 1946 (b) Huntington Williamson, M.D.
(Date rec'd by registrar)

VS 3

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 18 1946, at 530 a M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946, to 12-17 1946, and that I last saw him alive on 12-17 1946.

Immediate cause of death: Carcinoma of oesophagus — Duration 8 Mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. R. Johnson M. D.
Address 403 Medart Bg Date signed 12-18-46

G16611 BC# G63679 G16611

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 122B

Registered No. G16611

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2225 N. Howard ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert L. Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race N

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-14-46

8. AGE: Years | Months 1 | Days 3 3 | If less than one day hr. min.

9. Birthplace Baltimore Md (town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name James Williams
13. Birthplace Va.

MOTHER 14. Maiden Name Alice Henry
15. Birthplace Va.

16 (a) Informant James Williams
(b) Address 2225 Howard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore

18 (a) Funeral director Clark Cooter
(b) Address 512 N. Carrollton Ave

19 (a) DEC 18 1946 (Date rec'd by registrar) Cooter for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-17 1946, at 6 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9 1946, to 12-17 1946, and that I last saw him alive on 12-17 1946.

| Immediate cause of death | Duration |
|---|---|
| Intestinal Obstruction | |
| Due to Mesenteric Cyst | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 12-10-46
Major findings of operation: Mesenteric Cyst
of autopsy: Mesenteric Cyst

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H I B Higgins / J. Wilkes M. D.
Address 1514 Division St Date signed 12-17-46

VS 150

Please write plainly; all information about to carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16615

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 125a

G16615 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Dukeland & Rayner Ave
(c) Hospital or institution: West Baltimore Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 Union Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** James M. Stewart Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife Marguerite Stewart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6-1901

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 45 | 4 3 | 12 | hr. min. |

9. Birthplace Butler, Balto Co. Md
(Town, county, and state)
10. Usual Occupation Barber
11. Industry or business

FATHER
12. Name James M. Stewart Sr
13. Birthplace Baltimore Co. Md.

MOTHER
14. Maiden Name Rachael E. Benson
15. Birthplace Baltimore Co. Md.

16 (a) Informant Marguerite Stewart (wife)
(b) Address 1217 Union Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-46 (month) (day) (year)
(c) Cemetery or crematory Black Rock
Location Butler Balto Co. Md.

18 (a) Funeral director Wesley R. McNamee
(b) Address 4114 Hares Road

19 (a) (Sec'y or asst.) (b) Registrar

DEC 19 1946

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-17 1946 at 7.55 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15 1946, to 12-17 1946, and that I last saw h[im] alive on 12-17 1946.

| Immediate cause of death | Duration |
|---|---|
| Acute Congestive Failure | 2 days |
| Due to Urinary Shutdown | 4 days |
| Due to Acute Liver Necrosis | 6 days |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Berdinsky M. D.
Address WBGH Date signed 12/17/46

Please write plainly, with unfading ink. Every question must be answered, or the certificate will be returned for completion. Be sure to state the causes of death clearly and legibly. Statements of time, as required, should be carefully considered and accurately stated. The correct age is especially important. Physicians: please write the

D G16616

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G16616

Registered No. 319

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 516 N. Bradford St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 516 N. Bradford St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Freeman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race C

6. (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mary Freeman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1904

8. AGE: Years 42 | Months 9 | Days 9 | If less than one day hr. min.

9. Birthplace North Carolina
(Town, county and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Elie Freeman
13. Birthplace Va.

MOTHER
14. Maiden Name Katie Crawlie
15. Birthplace Va.

16 (a) Informant Mary Freeman
(b) Address 516 N. Bradford St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Ave

19 (a) Date rec'd by reg'r 12-18-46 (b) Huntington Wilson Registrar

**MEDICAL CERTIFICATION**

12/13/46

20. DATE OF DEATH Dec. 13 1946, at 1st M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-15 1946, to 12-14 1946, and that I last saw him alive on Dec 13 1946.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | |
| Due to Arteriosclerosis | |
| Due to Hypertension with C.V.D. | |
| Other Conditions Uncs. | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Morris A Fine M. D.
Address 118 W Saratoga St Date signed 12/17/46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16617

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1131a

Registered No. G16617

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1614 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 Jordan St (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

**3 (a) FULL NAME** Sylvester Chaney

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Elizabeth Chaney
6 (c) If alive, give age 79 years
7. Birth date of deceased (mo., day, yr.) March 25, 1877
8. AGE: Years 69 | Months 8 | Days 22 | If less than one day: hr. min.
9. Birthplace Calvert County (Town, county, and state)
10. Usual Occupation laborer
11. Industry or business

MOTHER / FATHER
12. Name Robt. Canada
13. Birthplace
14. Maiden Name
15. Birthplace

16 (a) Informant Elizabeth Chaney
(b) Address 1115 Jordan St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md
18 (a) Funeral director Geo. L. Kelson
(b) Address 1303 Preastman
19 Date received by registrar DEC 18 1946 (b) Huntington Williams M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 1946 at 6 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 16th 1946, to Dec 16th 1946, and that I last saw h.. alive on Dec 16 1946.

Immediate cause of death: Cerebral Hemorrhage — Duration: 3 hrs
Due to: Hypertensive Cardio vascular Renal Disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
Means of injury

23. Signature Geo. McDonald M.D.
Address 814 N Carey Date signed 12/19/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6618 BC# BALTIMORE CITY HEALTH DEPARTMENT Registered No. G46618
AB-106526 G-63824 CERTIFICATE OF DEATH 159

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 869 W. Pierce Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Baby Girl Gross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 1-1946

8. AGE: Years | Months | Days: 12 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Evelyn Gross
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12-16-46 (month) (day) (year)
(c) Cemetery or crematory Balto City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) [illegible] (Date received by registrar) (b) Huntington Williams Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 13- 1946, at 8.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1 1946, to 12-13 1946, and that I last saw her alive on 12-13- 1946.

| | Duration |
|---|---|
| Immediate cause of death: Pneumonia | 3 days |
| Due to: | |
| Due to: Diarrhea | 4days. |
| Other Conditions: Prematurity | 12 days |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Pneumonia Bronchop

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julian P. Griffin
Address Baltimore City Hosps Date signed M. 12 D. 16 46

X

16619 16619

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 46 B

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 N. Dallas st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** ERNEST BROWN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-17-1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 2 | - | hr. min. |

9. Birthplace Texas (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Texas

MOTHER
14. Maiden Name Unknown
15. Birthplace Texas

16 (a) Informant Augusta Brown
(b) Address 1317 N. Dallas St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location Ann Arundel Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) DEC 18 1946 (Date rec'd by registrar) (b) Huntington Nathaniel Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 12/17 1946, at 10 45 M.

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar pneumonia, right lung

Due to Carcinoma of stomach

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George C. Merrill M.D. Medical Examiner.
Date signed 12/18/46

VS 151

G16620

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1163H

G16620 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 9-
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dit
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 E. 30th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Emilie Emillie Bittorf

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-03-6291

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | S |

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/24/96

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | | 23 | hr. min. |

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation telephone operator
11. Industry or business C. & P

FATHER
12. Name Fredk. W. Bittorf
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Anna E. Schoenbaka
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Wm Vogeler
(b) Address 1915 E. 30th St.

17 (a) Burial (b) Date thereof 12/20/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto
Location Balto. Md.

18 (a) Funeral director Lonsdale Funeral Home
(b) Address 5401 Belair Rd.

19 (a) DEC 18 1946 (b) Huntington Williamsport, Md.
(Date rec'd by registrar)

VS 181

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/17 1946, at 3:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxia due to
Illuminating gas
Due to
Other Conditions Drug addict
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/17/46 at abt 1:00 P M.
(b) Where did injury occur? 1915 E. 30th St
(c) Did injury occur at home, on farm, industrial place, in public place? At Home While at work? No
(d) Means of injury Inhalation gas from (3) unlighted burners

23. Signature C. J. Shulenberg M.D.
Medical Examiner.
Date signed 12/18/46

G16621 G16621

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1107

Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1313 Herkimer St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 Herkimer St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

**3 (a) FULL NAME** ONA. REMEIKIS

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex: Female | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John
(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 9-5-84

8. AGE: Years 62 | Months 3 | Days 12 | If less than one day: hr. min.

9. Birthplace Lith. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business ✓

FATHER 12. Name ? VAINAICIUS
13. Birthplace LITH.

MOTHER 14. Maiden Name ?
15. Birthplace LITH.

16 (a) Informant John Remeikis
(b) Address 1313 Herkimer St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Beldis Rd

18 (a) Funeral director Joseph Kasemekas
(b) Address 601 Washington Blvd.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 18 1946

VS-150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 12/17/46 19 , at 8 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from 9/1/46 19 , to 12/17/46 19 , and that I last saw her alive on 12/17/46 19

Immediate cause of death: Broncho-pneumonia — Duration: 48 hrs.

Due to

Due to

Other Conditions: Senile Dementia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23.** Signature C. J. Mendelis M.D.

Address 651 No. Bentalou Str Date signed 12/17/46

X

G16622

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93E

G16622 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2400 Druidhill ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo 10 dys

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County Amherst
(c) City or town Amherst
(If outside city or town limits, write RURAL and give town)
(d) Street No. Piney River P. O.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Morgan.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-15-1892

8. AGE: Years 54 | Months 6 | Days 2 | If less than one day hr. min.

9. Birthplace Amherst Virginia
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name John Rose
13. Birthplace Va.

MOTHER
14. Maiden Name Emma Osmed
15. Birthplace Va

16 (a) Informant Thomas Morgan
(b) Address Piney River P.O. Amherst Va

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12-18-46 (month) (day) (year)

(c) Cemetery or crematory Willis Cemetery
Location Amherst Virginia

18 (a) Funeral director William Jackson
(b) Address 916 Pemba ave

19 (a) (Date rec'd by registrar) (b) Huntington Registrar

DEC 18 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17, 1946, at 12 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 6, 1946, to Dec 17, 1946, and that I last saw her alive on Dec. 16, 1946.

| Immediate cause of death | Duration |
|---|---|
| Myocarditis | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. McDonald Bando M. D.

Address 2445 D. Hill Ave Date signed 12-17-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46623

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 171a

Registered No. G46623

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 25 D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2206 Sydney Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** JOSEPH E. CASTRANDA

3 (b) If veteran, name war: --

3 (c) Social Security Account No. 212-26-4521

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dorothy E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1910

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 36 | 11 | 10 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Reese Motors

11. Industry or business

FATHER
12. Name John Castranda
13. Birthplace Austria

MOTHER
14. Maiden Name Martha Doneski
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Dorothy E. Castranda
(b) Address 2206 Sidney Ave., Westport

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-46 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Western
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) DEC 18 1946 (Date rec'd by registrar) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 16, 1946, at 10.30 P M

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull
Intracranial hemorrhage
Due to Fractured ribs

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-16-46 10.10 p. M. 25/3
(b) Where did injury occur? Annapolis & Waterview Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Pediastrian-struck by St. car

23. Signature George H. Merrill M.D. Medical Examiner.
Date signed 12-17-46

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

Registered No. 666324

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: PROVIDENT 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 45

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town BALTIMORE 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Division St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** NANNIE M. LINDSAY

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| FE | N | MARRIED |

6 (b) Name of husband or wife HENRY LINDSAY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/9/1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 1 | 6 | hr. min. |

9. Birthplace NORTH CAROLINA (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business

FATHER
12. Name Wade Allen
13. Birthplace N C

MOTHER
14. Maiden Name Maria ?
15. Birthplace N C

16 (a) Informant Henry Lindsay
(b) Address 2041 W Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-19-46 (month) (day) (year)
(c) Cemetery or crematory Christian
Location Balto. Co.

18 (a) Funeral director Samuel W. Chase & Son
(b) Address 638 N. Gilmor St

DEC 18 1946 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 130

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/15 1946; at 1:36 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/8 1946 to 12/15 1946, and that I last saw h[illegible] alive on 12/15 1946

| Immediate cause of death | Duration |
|---|---|
| CARDIAC FAILURE | |
| Due to Hypertensive Arteriosclerotic Heart Disease | 7 Yrs. |
| Due to | |
| Other Conditions Acute Bacterial Endocarditis Perforation of ant. Cusp (Major operation within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Williams M.D.
Address 1514 Division St Date signed 12/17/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16625

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

147B

Registered No. G16625

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution:
University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) None

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MC (b) County Baltimore
(c) City or town Catonsville #25
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 3121 (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** Eva May Walker 364613

3 (b) If veteran, name war NO

3 (c) Social Security Account No. 216-05-7905

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife John Calvin Walker
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) Apr 25 1902

| 8. AGE: Years | Months | Days | If less than one day: hr. | min. |
|---|---|---|---|---|
| 44 | 7 | 21 | | |

9. Birthplace Carroll MC
(Town, county, and state)
10. Usual Occupation HW
11. Industry or business At Home

FATHER
12. Name Charles R. Lowe
13. Birthplace Virginia

MOTHER
14. Maiden Name Lottie King
15. Birthplace North Carolina

16 (a) Informant Eva Walker
(b) Address Catonsville MC

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 19, 1946 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Frederick Ave. Balto.
18 (a) Funeral director Easton Sons
(b) Address Ellicott City, Md.
(b) Date received by Registrar DEC 19 1946

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/16 1946 at 1:23 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/11 1946 to 12/16 1946 and that I last saw he alive on 12/16 1946

Immediate cause of death
Peritonitis

Due to Endometritis, Puerperal
Secondary to Cesarean

Due to Section for abnormal Presentation.

Other Conditions Pregnancy.

(Include pregnancy within 3 months of death)

Date of operation 12/14/46

Major findings of ~~Surgery~~: Walled off Cesarean - pelvic - Pyelonephritis - of ~~supply~~ left - t

| Duration |
|---|
| |
| |
| |
| over |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. Irvin W. Grayson M.D.
Address Union Hos Date signed 12-19-46

DEC 19 1946

X

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G166326

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 97

G166326 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2101 W. Cold Spring Lane
(c) Hospital or institution:
Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3641 Walbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Shaffer.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow.

6 (b) Name of husband or wife: Michael Shaffer.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown.

8. AGE: Years: about 85? Months: Days: If less than one day: hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace Unknown.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Unknown.

16 (a) Informant Rosa L. Bolan.
(b) Address 705 Perry St.

17 (a) Burial (b) Date thereof Dec 19/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Poplar
Location Balto Co. Md.

18 (a) Funeral director Ehrenfeld & Donovan
(b) Address 3615-17 Eastern Ave

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 19 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 17, 1946, at 1 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from APRIL 8, 1946, to December 17, 1946, and that I last saw her alive on December 16 1946.

| Immediate cause of death | Duration |
|---|---|
| ARTERIOSCLEROTIC GANGRENE RT. FOOT & LEG. | 2 wks. |
| Due to GENERALIZED ARTERIOSCLEROSIS | 15 yrs. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R. Klamm

Address 3803 Edmondson Ave. Date signed 12/18/46 D.

VS 10

X

G16627

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

937

G16637

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3701 N. Allendale St
(c) Hospital or institution: Frank Hall's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32 y

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Patapsco Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. Pata (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Director

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Joseph -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860

8. AGE: Years 86 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Domestic work

11. Industry or business

FATHER 12. Name Dawyn -
13. Birthplace R.

MOTHER 14. Maiden Name
15. Birthplace Russia

16 (a) Informant Frank Director
(b) Address 900 N. Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-19-46 (month) (day) (year)

(c) Cemetery or crematory Windsor Mill Rd
Location

18 (a) Funeral director Jack Levine Inc
(b) Address 1439 E. Balto St

19 (a) (b) Registrar
(Date rec'd by registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 18 1946, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 29 1942 to Dec 18 1946, and that I last saw h alive on Dec 17 1946

Immediate cause of death: Arteriosclerotic Cardiovascular Disease — Duration: 4 yrs

Due to Hypertension

Due to

Other Conditions Arteriosclerotic Heart Disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert F. Hunter M.D.
Address 2302 Clifton Ave Date signed 12/19/46

Huntington

R3a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G36628

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

8 3a

Registered No. G36628

Please write the causes of death clearly and legibly. Physicians: please write legibly. Correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 110 W. 23rd St
(c) Hospital or institution:
12-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits write RURAL and give town)
(d) Street No. 110 W. 23rd St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** James Henry Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Edith Hall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1906

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 40 | 3 | 19 | hr. min. |

9. Birthplace Charlotte Court House Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Henry Hall
13. Birthplace Charlotte Court House Va

MOTHER
14. Maiden Name Julia Ann Green
15. Birthplace Charlotte Court House Va

16 (a) Informant Edith Hall
(b) Address 118 W. 23rd St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Dec 20, 1946 (month) (day) (year)
(c) Cemetery or crematory Keyser W Va
Location

18 (a) Funeral director Mrs Viola R Williams
(b) Address 322 N Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec 17 1946 at 02:12 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1946 to Dec 17 1946 and that I last saw h[illegible] alive on Dec 17 1946.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemmorhage | 7 Days |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul O Holmes M. D.
Address 2329 Guilford Ave Date signed Dec 18 1946

V S 150

G16629 BG# 62804 G16629

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 157E

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument St. - Rutland
(c) Hospital or institution:
Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26dys
(e) Length of stay in Baltimore (yrs., mos., or days) 26dys.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. Belair Rd. #517 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Elizabeth Hoffman

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: S.

6 (b) Name of husband or wife: CHILD
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1946

8. AGE: Years | Months | Days: 26dys | If less than one day: hr. min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation CHILD

11. Industry or business

FATHER — 12. Name Paul Kaufman
13. Birthplace Germany

MOTHER — 14. Maiden Name Lillian Hoffman
15. Birthplace Balto Md.

16 (a) Informant LILLIAN HOFFMAN
(b) Address Belair Rd. #517

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 18 46 (month) (day) (year)
(c) Cemetery or crematory Kaufmann Cemetery
Location Balto. Co. Md.

18 (a) Funeral director Loyola Sinai Home
(b) Address 7401 Belair Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 19 1946

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 12 / 18 1946, at 9:45 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Nov. 23 1946 to Dec 18 1946, and that I last saw h[illegible] alive on Dec. 18 1946.

Immediate cause of death: Cardiac Failure — Duration
Bronchopneumonia
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Bronchopn.; Cong. Heart

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23.** Signature Stanley Yaffe, M. D.
Address Sinai Hosp Date signed Dec 19 46

Stanley Yaffe X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46630 G46630

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

46E

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 334 Calvert Sts, Baltimore 18
(c) Hospital or institution:
UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (~~yrs.~~, ~~mos.~~, or days) 8
(e) Length of stay in Baltimore (~~yrs.~~, ~~mos.~~, or days) 8

**2. USUAL RESIDENCE OF DECEASED:**
(a) State ARIZONA (b) County
(c) City or town NOGALES
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 SONOITA ST.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** WILLIAM JOHN CRUICKSHANK

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife MRS. WM. J. CRUICKSHANK
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) MAY 26, 1893

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | 6 | 22 | hr. min. |

9. Birthplace MASSACHUSETTS
(Town, county, and state)
10. Usual Occupation CUSTOMS AGENT
11. Industry or business

FATHER
12. Name CHAS. W. CRUICKSHANK
13. Birthplace CANADA

MOTHER
14. Maiden Name ISABELLE CALEY
15. Birthplace CANADA

16 (a) Informant WIFE
(b) Address 402 SONOITA St, NOGALES, ARIZONA

17 (a) Burial (b) Date thereof 12/21/46
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul st

19 (a) DEC 19 1946 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 18 1946, at 4:55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1946 to Dec 18 1946, and that I last saw him alive on Dec 18 1946

Immediate cause of death GENERALIZED PERITIONITIS — Duration 7 days

Due to PERFORATION of CECUM — 7 days

Due to INTESTINAL OBSTRUCTION — 14 days

Other Conditions ANNULAR CARCINOMA HEPATIC FLEXURE COLON

(Include pregnancy within 3 months of death)
Date of operation Dec 12 1946
Major findings of operation: GENERALIZED PERITONITIS, PERFORATION CECUM CARCINOMA
of category:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Evan B Chambers M. D.
Address UNION MEMORIAL HOSP Date signed Dec 19, 46

VS 150

40 G16631

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 113

Registered No. G16631

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 W. North Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lassie Tall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband: Brady W. Tall
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-13-67

8. AGE: Years 79 | Months 2 | Days 4 | If less than one day hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

**FATHER**
12. Name Joshua Vaughn
13. Birthplace Pa.

**MOTHER**
14. Maiden Name Sarah (Not Known)
15. Birthplace Pa

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Columbia Pa

18 (a) Funeral director Wilson Cook Inc
(b) Address 1217 E Cont St

19 (a) DEC 19 46 (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1946 at 6.05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-16 1946 to Dec-17 1946, and that I last saw him alive on Dec-17 1946.

Immediate cause of death: Heart Failure — Duration 3 yrs.

Due to: Arteriosclerosis — 10 yrs.

Due to: Hypertension — 3 yrs.

Other Conditions: Emphysema — 3 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dayton G Leavell

Address Johns Hopkins Hosp Date signed 12 Dec

VS 150

8 97

C16632

CWR-106631

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 77

Registered No. C16632

Please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 409 Ensor Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** S.
Emily [redacted] Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not known

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 ? | | | hr. min. |

9. Birthplace ?
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 12/20/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Balto Md

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 14 1946, at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12 1946, to Dec. 14 1946, and that I last saw h. er alive on Dec. 14 1946.

| Immediate cause of death | Duration |
|---|---|
| Peripheral circulatory failure | |
| Due to unknown cause | |
| Due to | |
| Other Conditions (1) Malnutrition (2) Dehydration (3) chronic alcoholism | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin C. Evans M. D.
Address Baltimore City Hospitals Date signed 12-18-46

VS 150

G16633

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

107

G16633 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2403 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2403 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Washington Clay McCoy

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Anna Mae Naylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1860

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 86 | 1 | 16 | hr. min. |

9. Birthplace Dames Quarter, Md.
(Town, county, and state)
10. Usual Occupation Sea Captain
11. Industry or business Dept. Com. Bureau Navigation

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Anna Mae Naylor
(b) Address 2403 Edmondson Ave.

17 (a) Burial (b) Date thereof Dec. 21, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Crisfield, Cemetery
Location Crisfield, Md.

18 (a) Funeral director Bradshaw Funeral Home
(b) Address Crisfield, Md.

19 (a) (b) (c)
(Date rec'd by registrar) Registrar

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18, 1946, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15 1946, to 12-18 1946, and that I last saw h/M alive on 12-18 1946.

Immediate cause of death Broncho-pneumonia — Duration 6 days

Due to

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M W. Jacobsen M. D.
Address 2314 Eutaw Place Date signed 12-19-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16634

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

12 12

G16634 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 6004 York Rd.
(c) Hospital or institution:

27 12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6004 York Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** IDA LOUISE KELBAUGH

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Married |

6 (b) Name of husband Frederick E. Kelbaugh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 2 | 29 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name Edgar Shipley
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Katherine ?
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Frederick E. Kelbaugh, Husband
(b) Address 6004 York Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/46 (month) (day) (year)
(c) Cemetery Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa Aves. Balto. 17, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18/46 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1- 1946 to Dec 18- 1946, and that I last saw her alive on Dec-17- 1946.

| Immediate cause of death | Duration |
|---|---|
| Edema of Lungs | 1 day |
| Due to Mitral Stenosis - | 5 yrs |
| Due to | |
| Other Conditions Chronic Nephritis | 3 yrs |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E. North Ave Date signed Dec 18-46

V S 150

DEC 19 1946 Washington Williams M.D.

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16635

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 92B

Registered No. G16635

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2874 Woodbrook Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 4
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2874 Woodbrook Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** REGINA KAUFFMAN

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widow |

6 (b) Name of husband ~~or wife~~ Elmer W. Kauffman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26, 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 6 | 21 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name Charles Edw. Holbein
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Jones
15. Birthplace Balto. Md.

16 (a) Informant Mrs. J. M. Benson
(b) Address R.F.D. #14 Box 116 Richmond Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/46 (month) (day) (year)
(c) Cemetery ~~Kaufmann~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa Aves. Balto. 17, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/17/46 19..., at 10:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1945 to Dec. 15 1946, and that I last saw h. alive on Dec. 15 1946.

| Immediate cause of death | Duration |
|---|---|
| mitral dilatation heart | years |
| Hypertrophy - arteriosclerosis | |
| Due to Brachial asthma | years |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 622 Fawcett Ave. Date signed 12/20/46

V S 130

DEC 19

X

G16636

BALTIMORE CITY HEALTH DEPARTMENT X 93

# CERTIFICATE OF DEATH

✓ G16636 Registered No.

G16636

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St
(c) Hospital or institution: So. Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Early (If outside city or town limits, write RURAL and give town)
(d) Street No. 513 Franklin Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Kuyawa
3 (b) If veteran, name war No
3 (c) Social Security Account No. None
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Theresa F
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 5 1880
8. AGE: Years 66 Months 3 Days 11 If less than one day hr. min.
9. Birthplace Baltimore Balto (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business
MOTHER / FATHER
12. Name George Kuyawa
13. Birthplace Poland
14. Maiden Name Lena Banazach
15. Birthplace Poland
16 (a) Informant Albert F. Kuyawa
(b) Address 513 Franklin Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 20 46 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Garmanhill Rd
18 (a) Funeral director Martin F. Dippold
(b) Address 2110 Belair Rd
19 (a) (Registrar's signature) (b) Huntington Williams M.D. Registrar

DEC 20 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-16 1946 at 6 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 12-16 1946 to 12-16 1946 and that I last saw h[illegible] alive on 12-15 1946

| Immediate cause of death | Duration |
|---|---|
| Acute Pulmonary Edema | |
| Due to Arteriosclerotic Heart Disease | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Stephen H. Grindell M. D.
Address 128 Light St Date signed 12-16-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

16637

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 124B

✓ G16637 Registered No.

Please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1709 Caswell Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 Caswell (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Anna Unkrosagt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or ~~wife~~ Chas T. Unkrosagt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/23/1883

8. AGE: Years 63 | Months 9 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business At home

FATHER 12. Name Albert J Brooks
13. Birthplace Md

MOTHER 14. Maiden Name Henrietta Shaw
15. Birthplace Md

16 (a) Informant Chas Unkrosagt
(b) Address 1709 Caswell Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 20 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Rural

18 (a) Funeral director Uzzell Funeral Home
(b) Address 2008 Pleasant St

19 (a) 12-19-1946 (Date rec'd by registrar) (b) Hattie Lee Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17th 1946, at 6:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-Nov 1945 to 17-Dec 1946 and that I last saw her alive on 17-Dec 1946

| Immediate cause of death | Duration |
|---|---|
| Cirrhosis liver | 13 mo |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles W. Edmunds M. D.
Address 2246 The Alameda Date signed Dec 17-46

VS 150

G16638

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1314

G16638

Registered No.

Physicians: please write the causes of death clearly and legibly. Statements of age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1608 W. North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 W. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Pagels

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1871

8. AGE: Years 75 | Months 10 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name George H. Pagels
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Hailer
15. Birthplace Germany

16 (a) Informant Mrs. Adele Pagels
(b) Address 1608 W. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 20 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem
Location Baltimore Md.

18 (a) Funeral director Maurice Cook Dyer
(b) Address 1600 W. North Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 19 1946 Huntington

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18 1946, at 3-45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 19 1946, to Dec 18 1946, and that I last saw h[illegible] alive on Dec. 17 1946

Immediate cause of death — Duration

Due to Chr. Myocarditis — 1946

Due to Arteriosclerosis — 1946

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carl Baum M.D.

Address 1663 W North Ave Date signed 12/19/46

X

G16639

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1928

G16639 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3228 Kenyon ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3228 Kenyon ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie M. Dietz

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Harry H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2 - 1894

8. AGE: Years 52 Months 5 Days 15 If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business "

FATHER
12. Name Jacob Eck
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Fletcher
15. Birthplace Balto. Md.

16 (a) Informant Harry H. Dietz
(b) Address 3228 Kenyon ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Upper Balto. Co.

18 (a) Funeral director John A. Hogan
(b) Address 3000 E. Balto. St.

19 (a) (Date rec'd by registrar) (b) Registered Huntingdon

DEC 17 1946

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 1946, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3 1946, to Dec 17 1946, and that I last saw h.er alive on Dec 17 1946.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage (Rt. Side Hemiplegia) | Dec 16/46 |
| Due to arterial Hypertension | June 1945 |
| slight arterial sclerosis | — |
| Due to | |
| Other Conditions Relative Mutual Sufferer | — |

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature James F. Hammann M. D.

Address 722 N. Kenwood Date signed 12/17/46

G16640

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1131a

Registered No. G16640

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 121 N. Linwood ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-1
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town insert RURAL and give town)
(d) Street No. 121 N. Linwood ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Putley

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jo Lem
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4-18-57

8. AGE: Years 89 | Months 8 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business —

FATHER 12. Name Betsch
13. Birthplace Germany

MOTHER 14. Maiden Name Dorothea Roos
15. Birthplace Germany

16 (a) Informant Marie Jones
(b) Address 121 N. Linwood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 20-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave.

18 (a) Funeral director John A. Horan
(b) Address 3000 E. Baltimore St. Huntingdon Pharmacy

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1946 at 7 00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1946, to Dec 17 1946, and that I last saw her alive on Dec 16 1946

Immediate cause of death: Uremia - Chronic Nephritis — Duration 12/14/46
Cardio-Vascular-renal disease —
Due to: arterio-sclerosis —
Due to —
Other Conditions: Empty Bowel —
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Louis F. Krumrein M. D.
Address 722 N. Linwood Date signed 12/17/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G16641

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G16641 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5111 Whiteford Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5111 Whiteford Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** Albert M. Dumler

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-12-5224

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Alice J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7 1869

8. AGE: Years 77 | Months 5 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Dumler
13. Birthplace Bavaria

MOTHER
14. Maiden Name Anna Ridler
15. Birthplace Pa

16 (a) Informant Alice J. Dumler
(b) Address 5111 Whiteford Ave

17 (a) Burial (b) Date thereof 12/20/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hoy Redeemer
Location Belair Road

18 (a) Funeral director John G. Moran
(b) Address 3000 E. Baltimore St.

19 (a) DEC 19 1946 (b) Hunting for Milton M.
(Date rec'd by registrar) Registrar

VS 6

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1946, at 9:20 P. M.

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an inspection thereon and from the evidence obtained by said inspection find that said deceased came to his death on the day stated above.
(Autopsy or Inquiry) (Autopsy or Inquiry)

| | Duration |
|---|---|
| Immediate cause of death Arteriosclerotic cardio-vascular disease | 3 yrs. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Kammer Jr. M.D.
Medical Examiner.
Date signed 17 Dec. 46

G16612

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G16612 / 166

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 19-
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 W. Lexington Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Bernard Parker

3 (b) If veteran, name war: W.W. 2
3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Anita

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/7/1920

8. AGE: Years 26 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Statesville N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Zachariah Parker
13. Birthplace N.C.

MOTHER
14. Maiden Name Mame Hopkins
15. Birthplace Md.

16 (a) Informant Mame Parker
(b) Address 1705 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/46 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat
Location Md

18 (a) Funeral director Geo. D. Gelston
(b) Address 1303 Freedman St

19 (a) DEC 19 1946 (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** December 17, 1946, 11 P.M.

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH: Bullet wound of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-17-46 at 11.05 P.M.
(b) Where did injury occur? 1637 W. Lexington St.
(c) Did injury occur at home, on farm, industrial place, in public place Accused's Home While at work? No
(d) Means of injury Firearms

**23.** Signature Howard J. Mallett M.D.
Medical Examiner.
Date signed 12-18-46

VS 181

C16643

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 192B

Registered No. C16643

Please write the causes of death clearly and legibly. Physicians: please write age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1305 Winchester St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 Winchester St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Eliza Boone Queen

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: F | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Chas.
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 1881

8. AGE: Years: 65 | Months | Days | If less than one day: ____ hr. ____ min.

9. Birthplace: Md (Town, county, and state)

10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Duncan Boone
13. Birthplace: Md

MOTHER
14. Maiden Name: Cecelia Butler
15. Birthplace: Md

16 (a) Informant: Chas. Queen
(b) Address: 1305 Winchester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12/20/46 (month) (day) (year)
(c) Cemetery or crematory: Calvert Co.
Location: Calvert Co. Md.

18 (a) Funeral director: Mrs. H. Nelson
(b) Address: 1303 Presstman St

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 17 1946

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-16 1946, at 11:3 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-28-1946 to 12-16-1946 and that I last saw h[illegible] alive on 12-16-1946

| | Duration |
|---|---|
| Immediate cause of death: Heart failure | 10-28-46 |
| Due to: Mitral Regurgitation | to |
| Due to: | 12-16-46 |
| Other Conditions: | |

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Wayland E Jones
Address 1300 N Fremont Ave Date signed 12-17-46

Wayland E Jones X

G16644

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G16644 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 211 E. Lemon St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-2
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 Lemon St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mable Day

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Colored | Married |

6 (b) Name of husband or wife Cobrin Day
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Oct 6, 1892

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 | 2 | 12 | hr. min. |

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Tony Smith
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace Va.

16 (a) Informant Cobrin Day
(b) Address 211 Lemon St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/34 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Arbutus Md

18 (a) Funeral director Wm. H. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 19 34, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 19 XX to Dec 18 19 34
and that I last saw h alive on Dec 16 19 34.

| Immediate cause of death | Duration |
|---|---|
| Cardio Vascular Disease | 2 yr |
| Due to Broken Compensation | 4 mo |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Wm. H. Nelson M. D.
Address 938 Lenna Ave Date signed 12/29/34

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

VS 150

Dec 29 1934

16615

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 8 7 12

G16615 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or Institution: Mercy Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 St. Paul St.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Rollins

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10 1898

8. AGE: Years 48 | Months 3 | Days 5 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Laborer.
11. Industry or business Edgewood Arsenal.

FATHER: 12. Name Charles Rollins
13. Birthplace Baltimore, Md.
MOTHER: 14. Maiden Name Margaret Murphy
15. Birthplace Ireland

16 (a) Informant deceased
(b) Address

17 (a) Dec - 20 - 46 (b) Date thereof (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Memorial Cemetery
Location Balto - Md
18 (a) Funeral director Odell Funeral Home Inc
(b) Address 403 - E 25th St.
19 (a) DEC 19 1946 (Date rec'd by registrar) (b) Huntington Williams III Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 15 1946, at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1946 to Dec 15 1946, and that I last saw him alive on Dec 15 1946.

| | Duration |
|---|---|
| Immediate cause of death: Cardio - Resp Failure | |
| Due to: Pulmonary edema | 5 days |
| Due to: Toxic Poly neuritis | 3 months |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas F. Sowers M.D.
Address Mercy Hospital Date signed 12/15/46

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16616 BG# B23561 STANEY BALTIMORE CITY HEALTH DEPARTMENT X G16616

# CERTIFICATE OF DEATH ✓ 14

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Howard
(c) City or town Ellicott City Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) ✓
If yes, name country

**3 (a) FULL NAME** Wilma Stanley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Single |

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 24 1945

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 1 | 7 | 24 | hr. min. |

9. Birthplace University Hosp. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Walter Stanley
13. Birthplace North Carolina

MOTHER
14. Maiden Name Emma Elizabeth Beall
15. Birthplace Maryland

16 (a) Informant Walter Stanley
(b) Address Ellicott City Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 20 1946 (month) (day) (year)
(c) Cemetery or crematory St. Marys Cem
Location Sykesville Md.

18 (a) Funeral director Easton Home
(b) Address Ellicott City Md.

19 DEC 19 1946 (Date rec'd by Local Reg.) (b) Hunter for Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12-18 1946 at 8.40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-14 1946 to 12-18 1946, and that I last saw her alive on 12-18 1946.

| Immediate cause of death | Duration |
|---|---|
| (a) Hydrocephalus | |
| Due to Tuberculous meningitis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Harley M. D.
Address University Hospital Date signed 12-18-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G36617

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G36617

CMK-106685

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 118 N. Eden Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Tillery, Albert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Lillian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23-1903

8. AGE: Years 43 | Months 7 | Days 23 | If less than one day: hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Cornelius Tillery
13. Birthplace ?

MOTHER
14. Maiden Name Maggie Hunter
15. Birthplace ?

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 20, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Calv. Cem
Location Brooklyn Md

18 (a) Funeral director Elliott O. Wilson
(b) Address 1510 Orleans St

19 (a) DEC 19 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 1946, at 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 7 19 46 to Dec. 16 19 46, and that I last saw h im alive on Dec. 16 1946

| | Duration |
|---|---|
| Immediate cause of death: Uremia | |
| Due to: Chronic pyelonephritis | |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Chronic pyelonephritis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin C Evans M. D.
Address Balto. City Hospitals Date signed 12-16-46

X

VS 150

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G16618

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1108

Registered No. G16618

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 N. Fulton ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** JOAN M. SHEARER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 9-1942

8. AGE: Years: 4 | Months: 4 | Days: 10 | If less than one day: hr. min.

9. Birthplace Hazelton Penna
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Arthur C. Shearer
13. Birthplace Penna

MOTHER
14. Maiden Name Anna Sadak
15. Birthplace Penna

16 (a) Informant Arthur C. Shearer
(b) Address 205 N. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof DEC 21-1946 (month) (day) (year)
(c) Cemetery or crematory Good Shepard Cem
Location Rockland Md

18 (a) Funeral director Pratt C. B. M. Walter
(b) Address Pratt & Stricker Sts

19 (a) DEC 19 1946 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec. 19th 1946 at 6 10 A M

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

History of convulsions

Due to Intracranial hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 12/19/46

X

6719

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V 46E

Registered No. C16619

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution:
Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-9
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3706 Chesholm Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARGARET THRESA CAMELLA

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~xxxxx~~ Joseph Camella
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, (189) 1898

8. AGE: Years 58 (55) | Months 5 | Days 11 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name ? Manion
15. Birthplace Unknown

16 (a) Informant Mr. Joseph C. Camella, [redacted]
(b) Address 3700 Elm Ave.

17 (a) Burial (b) Date thereof 12/23/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~xxxxxxx~~ Larraine
Location Balto. Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address 409 North & Pa Aves. Balto. 17, Md.

DEC 19 1946

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1946, at 9.55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3 1946 to Dec 19 1946 and that I last saw her alive on Dec 19 1946.

| Immediate cause of death | Duration |
|---|---|
| Cardio-renal failure | |
| Due to Colon Malignancy Diverticulitis Coloyn | |
| Due to Hemorrhage Peritonitis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation Dec 13, 1946
Major findings of operation: Ca about
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. P. Colburn M. D.
Address Bon Secours Hosp Date signed 12-19-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G16650

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1946

G16650 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1822 N. Regester Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1822 N. Regester Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM Joseph SCHEUERMAN

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. | 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|---|---|
| no | none | M | W | Married |

6 (b) Name of husband or wife Ella E. (Daly)
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) June 23, 1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | 5 4 | 24 | hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business Produce Dealer

FATHER
12. Name Ludwig Scheuerman
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Myers
15. Birthplace Germany

16 (a) Informant William L. Scheuerman
(b) Address 5503 Ready Avenue

17 (a) Burial (b) Date thereof 12/20/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) DEC 19 1946 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17 1946 at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1946 to Dec. 17, 1946. and that I last saw him alive on Dec. 16, 1946.

| | Duration |
|---|---|
| Immediate cause of death: Cerebral thrombosis | 5 days |
| Due to Coronary occlusion | 6 Mos. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Edward L. Fitzgerald M. D.
Address 1613 E. North Ave. Date signed 12-18-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

501346
G16651

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V74a

G16651 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 820 S. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Maccentelli

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-28-1879

8. AGE: Years 67 Months 10 Days 19 If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Gerasin Gerasimo Maccentelli

13. Birthplace Italy Isabella Vivarelli

MOTHER 14. Maiden Name

15. Birthplace Italy

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 20 1946 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca

(b) Address 52 N. Morley

19 (a) DEC 19 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1946, at 7:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1- 1946, to Dec 17 1946 and that I last saw him alive on Dec 17 1946.

Immediate cause of death Aleukemic Myeloid Leukemia — Duration 4 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robt E. Austrian M.D.

Address The Johns Hopkins Hosp Date signed 17 Dec 46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16652 Lo Notary

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. G16652

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 131 N. Duncan
(c) Hospital or institution: 6-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 60
(e) Length of stay in Baltimore (yrs., mos., or days) 60

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 131 N. Duncan st (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Barbara Lekarvat

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 17 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | | | hr. min. |

9. Birthplace Austria Bohemia (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

**FATHER**
12. Name Joseph Ceska
13. Birthplace Bohemia

**MOTHER**
14. Maiden Name Not known
15. Birthplace Bohemia

16 (a) Informant Clement Chavat
(b) Address 131 N. Duncan st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balt Md

18 (a) Funeral director Frank Wack Son
(b) Address 900 N Eutaw st

19 DEC 19 1946 (Date rec'd by registrar) Huntington Wilkinson (Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 17 1946 at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1946 to Dec 17 1946 and that I last saw alive on Dec 16 1946

| Immediate cause of death | Duration |
|---|---|
| Cardiac Decompensation | 1 week |
| Due to Cardio Vascular Renal Disease | ? |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Pokorny M. D.
Address 2200 E Madison Date signed 12/19/46

VS 150

G16553

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

Registered No. G16553

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 606 Lyndhurst Street
(c) Hospital or institution: 16-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 68 Years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 Lyndhurst Street
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

**3 (a) FULL NAME** Henry J. Strohmer

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Katherine Stoffel
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 3 | 22 | -- hr. --- min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired Salesman
11. Industry or business Loudon Park Cemetery

FATHER
12. Name Andrew Strohmer
13. Birthplace Germany

MOTHER
14. Maiden Name Rosalie Eff
15. Birthplace Germany

16 (a) Informant Mrs. Henry J. Strohmer
(b) Address 606 Lyndhurst Street

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/20/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. W. Meares and Son
(b) Address 805 N. Calvert Street

19 (a) (Date received by Registrar) (b) Huntington Williams M.D. (Registrar)

DEC 19 1946

VS 186

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 17 1946, at 10.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Dec 17 1946, and that I last saw h-- alive on Dec 17 1946.

| Immediate cause of death | Duration |
|---|---|
| Coronary thrombosis | 1½ hrs |
| Due to Hypertension arteriosclerotic C.V.D. Disease | 5 yrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John F. Cadahan M. D.
Address 24 W. Fayette St Date signed 12/18/46

X

6651 — G 6651

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 53

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1035 Hollins St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Sipes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Gertrude Sipes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14 1873

8. AGE: Years 73 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Hostler

11. Industry or business

FATHER — 12. Name John W Sipes

13. Birthplace Baltimore Co Md

MOTHER — 14. Maiden Name Victoria Goroheff

15. Birthplace Maryland

16 (a) Informant John W Sipes Jr

(b) Address 5616 Oakland Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/46 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Woodlawn Md

18 (a) Funeral director Wilson Lord Lee

(b) Address 1211 E Fort Ave

19 (a) DEC 20 1946 (Date rec'd by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19-1946, at 11 53 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17-1946 to 12-19-1946, and that I last saw h/pat. alive on 12-19-1946.

| | Duration |
|---|---|
| Immediate cause of death: Respiratory Failure | |
| Due to: Pneumonia | |
| Due to: | |
| Other Conditions: Carcinoma of side of face | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Causey M. D.

Address University Hosp Date signed 12-19-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G16655

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G16655

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 826 Mc Cabe Ave
(c) Hospital or institution: 7

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 826 Mc Cabe Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Daniel W. Robinson

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| W | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Mabel S. Robinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 29th 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 11 | 20 | hr. min. |

9. Birthplace Balto. Co. Md.
(Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Pa. R. R.

FATHER
12. Name James Robinson
13. Birthplace Chestnut Ridge Md.

MOTHER
14. Maiden Name Mary Fidler
15. Birthplace York Co. Pa.

16 (a) Informant Mabel S. Robinson
(b) Address 826 Mc Cabe Ave

17 (a) Burial (b) Date thereof 12/21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) DEC 20 1946 (b) Funeral for Williams Home
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19th 1946, at 9 15 a M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 19 45 to Dec 19 1946, and that I last saw h[illegible] alive on Dec 18 1946.

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | |
| Due to Arteriosclerosis | |
| Cardiovascular Disease | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward B. Wolfe M.D.
Address 1331 Mott Ave Date signed 12-19-46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16656

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G16656

Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1900 Roland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1900 Roland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Louis Clonde Burch

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Constance B
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17 1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 7 | 2 | hr. min. |

9. Birthplace St Marys Co Md
(Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Conn Mutual Ins

FATHER 12. Name Charles A Burch
13. Birthplace St Marys Co Md

MOTHER 14. Maiden Name Sophie E Walter
15. Birthplace

16 (a) Informant F B Burch
(b) Address 1900 Roland Ave

17 (a) Burial (b) Date thereof 12/21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Near Cathedral
Location Balto Md

18 (a) Funeral director Wilson & Cook Inc
(b) Address 1317 N Eutaw St

19 (a) 12-20-1946 (b) Lexington Williams M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec 19 1946 at 12.25 AM

**21.** I certify that death occurred on the date above stated; that I attended deceased from May 1945 to Dec. 19 1946, and that I last saw him alive on Dec. 19 1946

Immediate cause of death
(a) Congestive Heart Failure — Duration 6 Months
Due to Hypertensive Cardio Vascular Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature Thomas Connolly M. D.
Address 11 E. Chase St Date signed 12/19/46

VS 150

G36657

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G36657

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1110 Sargeant St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1110 Sargeant St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3. (a) FULL NAME** Julia B. Ogden

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife: James B. Ogden
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 7 | 18 | hr. min. |

9. Birthplace A. A. Co. Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Thomas Collinson
13. Birthplace A. A. Co. Md.

MOTHER
14. Maiden Name Caroline Whittington
15. Birthplace Calvert Co. Md.

16 (a) Informant Lina Hudson
(b) Address 1110 Sargeant St.

17 (a) Burial (b) Date thereof 12/21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registered by (Signature) (c) (Address)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 18th 1946 at 7 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1940 to Dec 18 1946 and that I last saw h[illegible] alive on Dec 18, 1946.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | — |
| Due to Myocardial degen | — |
| Due to Arteriosclerosis | — |
| Other Conditions — | — |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation
of autopsy —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 516 Walbrook Date signed X 12 19 46

VS 150

G16658 G16655

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 104 N. Pine St.
(c) Hospital or institution: 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 104 N. Pine St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country no.

3 (a) FULL NAME Rachel Dowell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1885

8. AGE: Years 60 61 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name John Dowell
13. Birthplace Maryland

MOTHER 14. Maiden Name Anna Johnson
15. Birthplace Maryland

16 (a) Informant Lucy Lee
(b) Address 104 N. Pine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 21 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Maryland

18 (a) Funeral director Adolphus Hartrad
(b) Address 918 E. Fort Ave

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 20 1946 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 18, 1946 at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1946 to Dec. 16 1946, and that I last saw h[illegible] alive on Dec 16 1946.

Immediate cause of death Cerebral Hemorrhage — Duration 4 dys

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Thomas M. D.
Address 753 W Fayette Date signed Dec 16

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G16659

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46a

Registered No. G16659

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3412 Kenyon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Neese

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widower |

6 (b) Name of husband or wife Rose Neese
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 25th 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 1 | 22 | hr. min. |

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business City of Balto.

FATHER
12. Name Unknown Neese
13. Birthplace Germany

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mabel E. Romagnoli
(b) Address 3412 Kenyon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) DEC 20 19 (b) (Signature of registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 17th 1946, at 1 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-16- 1946, to 12-17- 1946, and that I last saw h.l.m. alive on 12-17-1946.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma - Rectum | |
| Due to (Emphysema) | |
| Due to | |
| Other Conditions generalized metastases | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis L. Goodall M. D.
Address 1700 Eutaw Pl. Date signed 12-19-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G16650

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G16650 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 612- E. Pratt Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** JAMES R. DAVIDSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Edna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 14 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 1 | 2 | hr. min. |

9. Birthplace Wrights Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Solomon Davidson

13. Birthplace Md

MOTHER 14. Maiden Name Emma Thomas

15. Birthplace Md

16 (a) Informant Edna Davidson

(b) Address 46 E Heath St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/46 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill Md

Location Jenny Township Co

18 (a) Funeral director Wilson Co Inc

(b) Address 124 E Ford St

19 (a) DEC 21 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 14, 1946, at 12.20 M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions Acute Pulmonary Edema

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Maddox M.D. Medical Examiner.
Date signed 12-14-46

VS 191

G16661

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 131a

G16661 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 623 N. CAROLINE ST
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7D
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 623 N. CAROLINE ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Addie Elsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F. | C. | widowed |

6 (b) Name of husband or wife WILLIAM
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/2/1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 5 | 15 | hr. min. |

9. Birthplace BALTO. MD.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name SAMUEL H. Giles
13. Birthplace Md.

MOTHER
14. Maiden Name SARAH HILLARD
15. Birthplace Md

16 (a) Informant ELMER Giles
(b) Address 837 N. CAROLINE St.

17 (a) BURIAL (b) Date thereof 12/21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LAUREL Cem.
Location

18 (a) Funeral director Joseph B. Lock
(b) Address 1302 N. Central Ave

19 (a) (b) Registrar
(Date rec'd by registrar)

DEC 20 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/17 1946 at 11:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-10-1946 to 12-17-1946 and that I last saw deceased alive on 12-17-1946

| Immediate cause of death | Duration |
|---|---|
| Cerebral Embolism | |
| Due to Heart | |
| Due to Chr. nephritis | 2 years |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. L. Lewy M.D.
Address 1420 G. Chase Date signed 12-19-46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16662

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH / 469

Registered No. G16662

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 W. Rayner St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Junius Barnes

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Colored | Married |

6 (b) Name of husband or wife Mary
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 11-24-1914

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 32 | — | 25 | hr. min. |

9. Birthplace Suffolk Va
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER 12. Name Andrew Barnes
13. Birthplace ?

MOTHER 14. Maiden Name Hattie ?
15. Birthplace N. C.

16 (a) Informant Rector
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 12-21-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore Md.

18 (a) Funeral director Williams & Jackson
(b) Address 916 Fulton ave

19 (a) DEC 20 1946 (b) Huntington Hill Registrar
(Date rec'd by registrar)

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Dec. 19 1946, at 9 — M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 12-19 1946 to 19 ; and that I last saw h[illegible] alive on 12-19 1946

Immediate cause of death Cancer of head & pancreas & metastasis — Duration 4 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation October 1943

Major findings of operation: Cancer of head of pancreas

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23.** Signature [illegible] Williams M. D.

Address Johns Hopkins Hosp. Date signed 12-19-46

6663
AB-

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

131a

G16663
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16yrs-1 mo- 19days
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1003 Calhoun Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Martha Wilson

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | Col. | Widow |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct.?-1869-or Oct 2-1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71-or-77 | 2 | 18? | hr. min. |

9. Birthplace Essex County, Virginia (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Seldon or Southern Holmes
13. Birthplace Virginia

MOTHER
14. Maiden Name Maria or Meriah Banks
15. Birthplace Virginia

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto. Md.
18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania Ave
19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION** PM

20. DATE OF DEATH Dec. 18 1946, at 1.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29- 1930 to 12-18 1946 and that I last saw her alive on 12-18 1946

| Immediate cause of death | Duration |
|---|---|
| Respiratory Failure | 5 min. |
| Due to Arteriosclerotic CVD with Coronary Art insufficiency | yrs. |
| Due to | |
| Other Conditions Chronic Arthritis | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No stone + Bronchopneumonia

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund B. Beacham M. D.
Address Balto City Hosp Date signed 12 Dec 46

VS 150

G46664

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 108

Registered No. G46664

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 113 W. York St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Catherine Brown

3 (b) If veteran, name war

3 (c) Social Security Account No. Married

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | |

6 (b) Name of husband or wife Charles Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 19

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 33 | | | hr. min. |

9. Birthplace D. C.
(Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name Albert Holmes
13. Birthplace —

MOTHER
14. Maiden Name Lula Lomax
15. Birthplace D. C.

16 (a) Informant Ethel Bayamore
(b) Address 922½ - F. St. S.W. Wash. D.C.

17 (a) (Burial, cremation, or removal) (b) Date thereof Dec 20-46 (month) (day) (year)
(c) Cemetery or crematory Washington, D.C.
Location

18 (a) Funeral director James A. Sayes
(b) Address 1142 Wedell St

19 (a) (Date rec'd by registrar) (b) Registrar

12-20-1946 Huntington Williams, M.D.

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 19, 1946, at 12:55 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madison M.D.
Medical Examiner.
Date signed 12-19-46

X

G16665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G16665

506539

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2214 Presstman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Augusta Winkler.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Max Deceased.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-10-1878

8. AGE: Years 68 | Months 2 | Days 9 | If less than one day: hr. min.

9. Birthplace Hungary.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Winkler Bzimet
13. Birthplace Hungary.

MOTHER
14. Maiden Name Julia Scheisinger
15. Birthplace Hungary.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITEL

17 (a) Burial (b) Date thereof Dec, 22, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location 3600 E Baltimore St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) DEC 20 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Dec - 19 1946, at 3.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec - 17 1946 to Dec - 19 1946 and that I last saw h[illegible] alive on Dec - 19 1946.

Immediate cause of death Coronary occlusion — Duration 4 days

Due to H C V D + A S H D — 3yrs

Due to Cause undetermined

Other Conditions Diabetes — 10yrs

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Howard
Address John Hopkins Date signed Dec 19 1946

X

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G46666

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G46666 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1629 Abbottston St.
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 Abbottston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** ANNIE MARTIN MITCHELL

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widowed |

6 (b) Name of husband ~~or wife~~ David S. Mitchell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 2, 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 8 | 16 | hr. min. |

9. Birthplace Calvary, Harford Co. Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

MOTHER / FATHER
12. Name Samuel Martin
13. Birthplace Harford Co. Md.
14. Maiden Name (Amanda) Bond
15. Birthplace Harford Co. Md.

16 (a) Informant Mr. David E. Mitchell, son
(b) Address 4604 Haddon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/46 (month) (day) (year)
(c) Cemetery ~~xxxxxxx~~ Mt. Zion
Location Harford Co. Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa Aves Balto. 17, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 20 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18/46 19, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 16-Sept 1946 to 18 Dec 1946 and that I last saw h Lt alive on 18-Dec 1946

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | 1 day |
| Due to Arteriosclerotic Cardio Vascular Disease | 3 mo |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas W. Edmunds M. D.
Address 2746 The Alameda Date signed 19 Dec 46

Thurlington Hitchcock, Inc.

X

G46667

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 124B

Registered No. G46667

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2354 Wilkins Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2354 Wilkins Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward H. Nirdlinger

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 100-16-1408

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Kathleen M.
6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) March 21-1888

8. AGE: Years 58 | Months 8 | Days 28 | If less than one day ____hr. ____min.

9. Birthplace Cuba Alabama (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Clothing Co

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Kathleen M. Nirdlinger
(b) Address 2354 Wilkins Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 22-1946 (month) (day) (year)
(c) Cemetery or crematory Good Shepard
Location Rockland Md

18 (a) Funeral director Pratt Co B. M. Walters
(b) Address Pratt & Stricker Sts

19 (a) Dec 20 1946 (Date rec'd by registrar) (b) Hunting for Williams Registrar

VS 190

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 19, 1946, at 6:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1946 to Dec. 1946, and that I last saw him alive on Dec. 19 1946

| Immediate cause of death | Duration |
|---|---|
| Acute Congestive failure | |
| Due to Hypertension | yrs |
| Due to | |
| Other Conditions Cirrhosis of the liver | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis R. Mase M.D.
M.D. Address 4377 Park Heights Ave Date signed 12/19/46

102

G16668

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 49a

G16668 Registered No.

Make the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 543 Maunde Ave
(c) Hospital or institution: 1/2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 543 Maunde Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Clara Marie Svoboda

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | |

6 (b) Name of husband or wife Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3 - 1862

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 84 | 9 | 14 | hr. min. |

9. Birthplace Germany
(Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Pelkert
13. Birthplace Germany

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mrs Hickenlooper
(b) Address 2429 Wash Blvd

17 (a) Burial (b) Date thereof 12/16/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Roland Ave.

18 (a) Funeral director Edward Faulkner
(b) Address 2337 Wash Blvd

19 (a) DEC 20 1944 (b) Huntington, Md.
(Date received by registrar) (Examiner, Coroner)

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec-19 1944, at 12:30 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1944 to Dec-19 1944, and that I last saw h[illegible] alive on Dec-18 1944.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of Left Ovary with Intestinal | ? |
| Due to Metastasis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Lubin M.D.
Address 320 Ostego Ave Date signed 12/19/44
M. D.

G16669

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 6131a

Registered No. G16669

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. High St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Goff, Frank Thomas

3 (b) If veteran, name war: WWI

3 (c) Social Security Account No. 212-24-9526

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 2 | 15 | hr. min. |

9. Birthplace New York, NY (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Goff
13. Birthplace Newport, RI

MOTHER
14. Maiden Name Katherine Broadrich
15. Birthplace ?

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 21-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore Md.
18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave.
19 (a) (Date rec'd by registrar) (b) Huntington Ave Hillsgrove

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 18 1946 at 2:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 16 1946 to Dec. 18 1946 and that I last saw him alive on Dec. 18 1946.

| | Duration |
|---|---|
| Immediate cause of death: Nephrosclerosis severe | UNKNOWN |
| (2) Aortitis, chronic | UNKNOWN |
| Due to | |
| Due to | |
| Other Conditions Complication uremia | UNKNOWN |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson, Surgeon M. D.
Address Clinical Director Date signed 12/19/46

VS 150

correct age is especially important. Physicians: please write clearly and legibly.

G46670 BALTIMORE CITY HEALTH DEPARTMENT G46670

# CERTIFICATE OF DEATH ✓57E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4601 Park Heights Ave
(c) Hospital or institution: Mt. Carmel Home 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 36

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2303 Windsor Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Siegel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 71 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Bernard Siegel
13. Birthplace Poland

MOTHER 14. Maiden Name Rebecca Leith
15. Birthplace Poland

16 (a) Informant Albert H. Leventhal
(b) Address 1300 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location

18 (a) Funeral director Jacob Levin & Sons
(b) Address 1719 E. Balto. St.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 20 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/19/1946, at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 1946, to Dec 19 1946, and that I last saw h alive on 19.

Immediate cause of death: Neoplasm Left Lung — Duration: few months

Due to Massive Pulmonary Hemmorhage — Duration: 10 minutes

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alex D Weinstock M. D.

Address 4603 Park Heights Ave Date signed 12/19/46

VS Huntington Williams, M.D. X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REG. NO. 2113 PHONE, LIBERTY 5390

DR. ALEXANDER A. WEINSTOCK

4503 PARK HEIGHTS AVENUE

OFFICE HOURS: 10.30 TO 12 NOON – 5.30 TO 8 P. M.

TUESDAY: 5.30 TO 7 P. M. SUNDAY: 12 TO 2 P. M.

NAME _____

ADDRESS _____

℞

This man was at
Sinai when the
above diagnosis
of lung Tumor
was made. I spoke
to his wife
tonight
Alex Weinstock

FULL NAME _____ M. D.

G16671

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G16671

Registered No. 47

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3431 E. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Robert J. Milholland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19-1887

8. AGE: Years 59 Months 3 4 Days 29 If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER 12. Name John E. Milholland
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Ellen Mackey
15. Birthplace Ireland

16 (a) Informant Margaret Linden
(b) Address 3431 E. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/46 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Frederick Rd.

18 (a) Funeral director John G. McCann
(b) Address 3000 E. Balto. St.

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18/1946, at 9:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/9 1946, to 12/18 1946 and that I last saw h. alive on 12/18 1946.

Immediate cause of death — Duration

Cardio Respiratory Failure

Due to Pneumonia (Bronchial)

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cerebral Hemorrhage

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Helen Jaworski M. D.

Address St. Joseph's Date signed 12/18/46

VS 11

DEC 20 1946

Huntington Williams, M.D.

Birth Certificate
G-66772
G-65793

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 159

Registered No. G-66772

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2430 Madison ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2430 [redacted] Madison ave
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

**3 (a) FULL NAME** Infant Randall

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | c. | — |

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec-14-46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | 2 hr. min. |

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER
12. Name Isaac Randall
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Venus Freeman
15. Birthplace Baltimore Md

16 (a) Informant Laura Chambers
(b) Address 2430 Madison ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director George H. Nelson
(b) Address 1203 Preston corner St

19 (a) [illegible] (Date received by Registrar) (b) Huntington Ave Registered

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec-14- 1946, at 9:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-14 1946, to Dec-14-1946 and that I last saw h. alive on Dec-14 1946

| Immediate cause of death | Duration |
|---|---|
| Premature birth | |
| Due to Placental | |
| Due to separation | |
| Other Conditions — | |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Dr. Herman Beidel M. D.
Address 1101 Eutaw pl Date signed 12/[illegible]/46

Duplicate — AR-103886

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G166673

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) Two-Months
(e) Length of stay in Baltimore (yrs., mos., or days) 68yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1110 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Tilghman

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | Col. | Widower |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23- 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 10 | 25 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ezekiel Tilghman
13. Birthplace Maryland

MOTHER
14. Maiden Name Rachael Grooms
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals-Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Dec. 20, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Geo. A. Hallam
(b) Address 1631 Druid Hill Ave.

19 (a) DEC 20 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18- 1946, at 8:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19- 1946 to 12-18 1946, and that I last saw h im alive on 12-18 1946.

Immediate cause of death: Respiratory Failure — Duration

Due to: Arteriosclerotic CVD

Due to:

Other Conditions: Auricular Fibrillation
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elmer D. Beadlan M.D.
Address Bellevue Hosp. Date signed 19 Dec 46

X

G16671

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 180

G16674 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 526 Eislen Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** GEORGE HARROD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years 43 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Samuel Harrod

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Hattie Robinson

15. Birthplace Va

16 (a) Informant: Eleanor Coston

(b) Address 6396 W Mosher Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/46 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location A A Co Md

18 (a) Funeral director Isaiah L Brownson

(b) Address 1084 Montgomery St

19 (a) DEC 20 1946 (Date rec'd by registrar) (b) Huntington Williamson, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 16, 1946, at 10 p. M

21. I certify that I took charge of the remains described above, held an insp.& inq. Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to conflagration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 12-16-46 9.15 p. M.

(b) Where did injury occur? 526 Eislen St.

(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No

(d) Means of injury Oil stove turned on-unlit

23. Signature George G. Merrill M.D.
Medical Examiner.

Date signed 12-17-46

VS 151

G16675

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1946

Registered No. G16675

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2259 N. Pine St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2259 N. Pine St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Gertrude Culbert

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Col | Widow |

6 (b) Name of husband or wife Harry Culbert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 4 | 22 | hr. min. |

9. Birthplace Eastern Shore Md.
(Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Franklin Travers
13. Birthplace Eastern Shore Md

MOTHER
14. Maiden Name Sarah Hayden
15. Birthplace Md.

16 (a) Informant Landonia Hayden
(b) Address 2259 N. Pine St

17 (a) Burial (b) Date thereof Dec 21 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 822 N. Schroeder St.

19 (a) DEC 20 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Dec 17 1946 at 6:00 A M

**21.** I certify that death occurred on the date above stated, that I attended deceased from 12/15/1946 to 12/17/1946 and that I last saw h[illegible] alive on 12/17/1946

| Immediate cause of death | Duration |
|---|---|
| Myocardial infarction | |
| Due to Chr Myocarditis + Arteriosclerosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature W. Howard M. D.

Address 601 N. Arrow Ln. Date signed 12/21/46

V S 150

G16676

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

181

Registered No. G16676

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 810 Georg Street
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Pauline Layton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5 Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1940

8. AGE: Years 6 | Months - | Days 4 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation School

11. Industry or business

FATHER
12. Name John Layton
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Lecato
15. Birthplace Accomac Co. Va

16 (a) Informant Mary Layton
(b) Address 810 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 21 1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mr. Katie R. Gilliard
(b) Address 322 N. Schroeder St

19 (a) DEC 20 1946 (Date rec'd by registrar) (b) [illegible] Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 18, 1946, at 2 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Extensive BURNS

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-17-46 at 9:15 P. M. 17/3
(b) Where did injury occur? 810 George Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? NO
(d) Means of injury Clothes became ignited with [illegible]

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 12/18/46

VS 151

G16677

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

Registered No. G16677

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1626 Madison Ave
(c) Hospital or institution:
14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David T. Gross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alice Gross

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1881

8. AGE: Years: 65 | Months: 10 | Days | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Nathan Gross
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca
15. Birthplace Md.

16 (a) Informant Elizabeth McLaurin
(b) Address 1626 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 22, 1946 (month) (day) (year)
(c) Cemetery or crematory Western Star Cem.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 222 N. Schroeder St.

19 (a) DEC 20 1946 (Date rec'd by registrar) (b) Houston for Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18/ 1946 at 8:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-11-1946 to 12-18-1946 and that I last saw h/m alive on 12-17-1946.

| Immediate cause of death | Duration |
|---|---|
| Arterio-sclerotic gangrene of right leg | |
| Due to Arteriosclerosis | |
| Due to | |
| Other Conditions Hypertensive cardio-vascular disease | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C.R. Campbell M. D.
Address 718 Dolphin St. Date signed 12-19-46

V S 150

G16678

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48B

Registered No. 64628

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33 E. Ostend St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore City,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 33 E. Ostend St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Catherine Louise Schwemm,

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| -- | -- |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Henry Schwemm,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 5 | 13 | hr. min. |

9. Birthplace Baltimore City,
(Town, county, and state)
10. Usual Occupation Housewife,
11. Industry or business at home

FATHER
12. Name Eckhardt Schmidt,
13. Birthplace Germany,

MOTHER
14. Maiden Name Margaret Becker,
15. Birthplace unknown

16 (a) Informant Mr. Henry C. Schwemm,
(b) Address 2324 W. Lanvale St.

17 (a) Burial (b) Date thereof 12/21/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore City.

18 (a) Funeral director L. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) DEC 20 1946 (b) Huntington Williams
(Date rec'd by local registrar) Registrar

V S 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 18, 1946, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/22 1946 to 12/18 1946, and that I last saw her alive on 12/ 1946

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of stomach with general metastases | 1 year |
| Due to — | |
| Due to — | |
| Other Conditions Diabetes | 2 |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry C. Schwemm M. D.
Address 1224 Hanover St. Date signed

G16679

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48a

Registered No. G16679

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3526 6th. St. Brooklyn
(c) Hospital or institution: - - - -
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) Unkown

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3526 6th. Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anna Webster

3 (b) If veteran, name war - - -

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife Eugene

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-27-1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 11 | 21 | - hr. - min. |

9. Birthplace Phila., Penna.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name James J. Spenser
13. Birthplace Phila.

MOTHER
14. Maiden Name Catherine Marion
15. Birthplace Phila.

16 (a) Informant Eugene Webster, Husband
(b) Address 3526 6th. St; Brooklyn

17 (a) Burial (b) Date thereof 12-21-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Washington Blvd; Elkridge

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Wolfe Street

19 (a) 12-20-1946 (Date rec'd by registrar) Interred for Williamsville

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec- 18 1946, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1944, to Dec 18 1946, and that I last saw her alive on Dec- 17 1946

| Immediate cause of death | Duration |
|---|---|
| Terminal Pneumonia | 5 days |
| Due to Generalized Metastasis | 6 months |
| Due to Carcinoma of Cervix | 2 1/2 yrs |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Luther M. D.
Address 320 Pratt Street Date signed 12-19-46

V S 150

16680

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. C16680

83a

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Hours
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 300 North Pulaski (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

**3 (a) FULL NAME** LEWIS H. MILLER

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-4141

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | |

6 (b) Name of husband or wife Elsie D. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 2 | 4 | hr. min. |

9. Birthplace Peoria Ill. (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Gunther Brewery

FATHER
12. Name Unknown
13. Birthplace Peoria, Ill.

MOTHER
14. Maiden Name Unknown
15. Birthplace Peoria, Ill.

16 (a) Informant Mrs. Ruth Fleming
(b) Address 300 N. Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-46 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore

18 (a) Funeral director Frederick A. Gole
(b) Address 1200 W. Lombard St.

19 (a) DEC 20 1946 (Date received by Local Registrar) Huntington Williams M.D. (Local Registrar)

VS 191

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/20/46 19..., at 1A. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage
Due to Hypertension
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?.....
(d) Means of injury.....

23. Signature R. Davis, M.D. Medical Examiner.
Date signed 12-20-46

16GGS1

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. G16GS1

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4028 N. Rogers Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4028 N. Rogers Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lillian E. Long

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife John H. Long
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) March 2, 1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 9 | 17 | hr. min. |

9. Birthplace Baltimore City, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Frederick C. Roeseke
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Hoefling
15. Birthplace Germany

16 (a) Informant Mr. C. R. Kellner
(b) Address 4410 Groveland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 23, 1946 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Miller Lawrence
(b) Address 4510 Liberty Heights Ave.

19 (a) DEC 21 1946 (Date rec'd by registrar) (b) Hunter-Lee-Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 19 1946, at 9.50PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-12 1943 to 12-19 1946, and that I last saw her alive on 12-19 1946.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 3 hours |
| Hypertension | 7 years |
| Due to Generalized Arteriosclerosis | 7 years |
| Due to | |
| Other Conditions None | |

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy Not done

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Leon Adelman M. D.
Address 1201 Poplar Grove St Date signed 12-20-46

VS 196

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16682

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. G16682

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3110 Brightwood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 68 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3110 Brightwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Frank Emory Cunningham

3 (b) If veteran, name war

3 (c) Social Security Account No. 326-05-2115

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Nellie W. Cunningham
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 3 | 4 | hr. min. |

9. Birthplace New Freedom, Pa. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Nat'l Washboard Co., Chicago, Ill.

FATHER
12. Name William F. Cunningham
13. Birthplace West Virginia

MOTHER
14. Maiden Name Rebecca E. Kramer
15. Birthplace Maryland

16 (a) Informant Mrs. Nellie W. Cunningham
(b) Address 3110 Brightwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 21, 1946 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Park Cem.
Location Baltimore, Md.

18 (a) Funeral director Miller Lamborn
(b) Address 4510 Liberty Heights Ave.

19 DEC 21 1946 (Date rec'd by registrar) by Funeral Director for Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** December 18 1946, at 5.40P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Sept 18 1946, to Dec 18 1946, and that I last saw h[illegible] alive on Dec 18 1946.

Immediate cause of death: Chronic interstitial nephritis — Duration 1 yr. 3 mos.
Due to: Arteriosclerosis — 5-1/2 yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23. Signature** G. W. Billups M. D.
Address 2224 W. North Ave. Date signed 12/20/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G16683

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 195E

Registered No. G16683

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 538 S. Hawkins Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Otto Laiten

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | 213-07-5890 |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 15, 1892

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 | 8 | 4 | hr. min. |

9. Birthplace Finland
(Town, county, and state)

10. Usual Occupation
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name ? Laiten
13. Birthplace Finland

MOTHER
14. Maiden Name Unknown
15. Birthplace Finland

16 (a) Informant Mrs. Cecelia (Pelina) Zimmerman
(b) Address 639 S. Oldham Street

17 (a) Burial (b) Date thereof 12-21-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) DEC 21 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19- 1946, at 1.35 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull - Intracranial Hemorrhage - Laceration of brain.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at 26/7 M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? P. P. While at work?
(d) Means of injury

23. Signature Howard J. Mennen M.D.
Medical Examiner.
Date signed 12-19-46

VS 151

AB -106403 BC# 663510 BALTIMORE CITY HEALTH DEPARTMENT Registered No. 016684

6681 CERTIFICATE OF DEATH 159

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1402 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Girl Pugh

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26- 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 17 | hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Paul Gilbert
13. Birthplace ?

MOTHER
14. Maiden Name Eunice Pugh
15. Birthplace N.C.

16 (a) Informant Records, Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremation (b) Date thereof 12-17-46
(Burial, cremation, or removal) (month) (day), (year)
(c) ~~Cemetery or crematory~~ Balto City Hospitals
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

19 (a) DEC 21 1946 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 13 1946, at 10.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-26- 1946, to 12-13 1946, and that I last saw h. alive on 12-13- 1946.

| | Duration |
|---|---|
| Immediate cause of death Atelectasis | 3 hrs |
| Due to Prematurity | 3 hrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Atelectasis, Hyptonagh Pulmonary

**PHYSICIAN**
Underline the cause to which death should be charged statis-

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julian P. Griffin M. D.
Address Balt. City. Hosps. Date signed Dec 17 1946

G16685

J1 -91576

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

133

Registered No. G16685

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 11- 6
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2305 Foster Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Mary Bukowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widowed |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 8 | 4 | hr. min. |

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Michael Muniuk
13. Birthplace Poland

MOTHER
14. Maiden Name Sophie Putck
15. Birthplace Poland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 23/46 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore

18 (a) Funeral director Fred W Ozazewski
(b) Address 1930 Eastern Ave

19 (a) DEC 21 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1946, at 1.40A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 13 1945 to Dec. 19 1946 and that I last saw h. alive on Dec. 19 1946

Immediate cause of death: Pulmonary T.B. — Duration: yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H S Hart M. D.
Address Balto City Hosp Date signed Dec 20-46

G16689 ✓ G16686

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2122 St. Paul Street
(c) Hospital or institution: home 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2122 St. Paul St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country No

3 (a) **FULL NAME** Lillian Hancock Eberle

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. | 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|---|---|
| None | None | Female | White | Widow |

6 (b) Name of husband or wife Eugene G. Eberle
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 3, 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 9 | 16 | hr. min. |

9. Birthplace Balto. - Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business — —

FATHER
12. Name John F. Hancock
13. Birthplace Md.

MOTHER
14. Maiden Name Frances Etchberger
15. Birthplace Balto. - Md.

16 (a) Informant Dr. Jas. E. Hancock (Brother)
(b) Address 2122 St. Paul St. - City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-1946 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. - Md.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. MOWEN SON.) 100 W. DEWEY AVENUE

19 (a) — (b) Huntington Williams, M.D. Registrar
(Deputy registrar)

DEC 21 1946

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 19 1946, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1946, to Dec 19 1946 and that I last saw h[illegible] alive on Dec 19 1946.

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | 2 Days |
| Due to Arterial Sclerosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. H. Pearce M. D.
Address 2105 Charles Date signed Dec 20 46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C16687

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

121a

Registered No. C16687

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore 31.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 408. S. Fran. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore. S. Skrzynski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 [illegible]/03

8. AGE: Years 43 | Months 1 | Days 10 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Shipping Clerk

11. Industry or business Montgomery + Wards

FATHER
12. Name Wladislaw Skrzynski
13. Birthplace Poland

MOTHER
14. Maiden Name Veronika Stachowiak
15. Birthplace Poland

16 (a) Informant Rev. Thad. Skrzynski
(b) Address Church Lane Pikesville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. J. Fialkowski
(b) Address 2007 Eastern Ave
(c) Huntingtown Williams, Md.

DEC 21 1946 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19-46 19 at [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-19 1946 to 12-19 1946 and that I last saw h. alive on 12-19 1946

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertension

Due to Chronic Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry J. Wilson Jr. M. D.
Address St. Joseph's Hosp Date signed Dec 19 1946

VS 150

5688

BALTIMORE CITY HEALTH DEPARTMENT

AB-106269

# CERTIFICATE OF DEATH

46B

Registered No. G16688

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 55yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 Springfield Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Cole

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30-1873

8. AGE: Years 73 Months 5 Days 18 If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Laundry Work

11. Industry or business

FATHER
12. Name Nick
13. Birthplace Virginia

MOTHER
14. Maiden Name Emily Mattocks
15. Birthplace Va.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12-29-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pleasant Rest
Location Towson Md.

18 (a) Funeral director Patterson & Smith & Wright
(b) Address 72 Wilquette St

19 (a) 12-4-1946 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION PM

20. DATE OF DEATH Dec. 18-1 1946, at 4.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-21- 1946 to 12-18 1946, and that I last saw h. in alive on 12-18- 1946

Immediate cause of death Generalized peritonitis

Due to [redacted] Intestinal obstruction and disruption.

Due to Carcinoma.

Other Conditions Carcinoma of Splenic with metastases to liver

(Include pregnancy within 3 months of death)

Date of operation 11/21/46 and 12/2/46

Major findings of operation: Carcinoma of splenic with hepatic metastases.

Of autopsy: as above

| Duration |
|---|
| |
| |
| |
| |
| |

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. J. Gibbs M. D.
Address Baltimore City Hospitals Date signed 12/19/46

Hunter for Williams, M.E.

X

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G16689

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1702 Presbury St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 Presbury St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Susie Lewis

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John N. Lewis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1892

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | 11 | 23 | hr. min. |

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Cornelius Brooks
13. Birthplace Va

MOTHER
14. Maiden Name Jane Brooks
15. Birthplace Va

16 (a) Informant John W. Lewis
(b) Address 1702 Presbury St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-46 (month) (day) (year)
(c) Cemetery or crematory Centerwood Va
Location Va

18 (a) Funeral director George G. Nelson
(b) Address 1303 Pennsylvania Ave

19 DEC 21 1946 (Date died) (day) (year) (b) Huntington Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1946, at 10:45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 28 1946 to Dec 17 1946 and that I last saw h— alive on Dec 17 1946

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage due to | 1 day |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.
Address 1303 Eutaw Pl Date signed 12-20-46

VS 150

G16690

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

Registered No. G16690

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: Eaton and Wilkens Ave
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 542 E. Fort Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Dora Montgomery

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife: Forever

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13 1870

8. AGE: Years 76 | Months 5 | Days 6 | If less than one day hr. min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business ?

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Lowe ?
15. Birthplace ?

16 (a) Informant Family
(b) Address 542 E. Fort Ave

17 (a) D. (Burial, cremation, or removal) (b) Date thereof 12-23-46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn Md

18 (a) Funeral director Green & McCauley
(b) Address 132 E. Fort Ave

19 (a) 12 21 1946 (Date rec'd by Registrar) (b) Huntington for Witt Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/19 1946, at 11:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/11 1946 to 12/19 1946 and that I last saw her alive on 12/19 1946

Immediate cause of death Cardiac failure - Staphylococcus Septicemia - 9 d's

| Duration |
|---|
| |

Due to Arteriosclerosis Diabetes mellitus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. W. Wilson M. D.
Address Stayton Date signed 12/14/46

correct age is especially important. Physician: please write the

VS 150

G16691

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1463

Registered No. G16691

Please write the causes of death clearly and legibly. Physicians: please write the exact age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2602 Hamilton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2602 Hamilton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Annie M. Hetz
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Nicholas Hetz
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 23rd 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 10 | 20 | 7 hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Christoph Diening
13. Birthplace Germany

MOTHER
14. Maiden Name Anna E. Lopper
15. Birthplace Germany

16 (a) Informant J. H. Hetz
(b) Address 2602 Hamilton Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 22 46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.
18 (a) Funeral director Lansdale Funeral Home
(b) Address 7401 Belair Rd.
19 (a) 12 21 1946 (Date rec'd by Registrar) (b) Huntington Willis Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19th 1946, at 3:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1946, to Dec 19 1946 and that I last saw her alive on Dec 19 1946.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of Stomach | over 10 wks |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. Bevyer M. D.
Address 4808 Harford Rd Date signed 12/20/46

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 186a

Registered No. 616693

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution:
Union Memorial Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3921 Keswick Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs. Cassie Yoe

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Michael T. Yoe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1853

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 93 | 4 | 19 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Michael Moylan
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Elizabeth Daly
15. Birthplace Baltimore

16 (a) Informant U.M.H. records
(b) Address 33rd & Calvert Sts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Maryland

18 (a) Funeral director H. H. Mears and Son
(b) Address 805 N. Calvert St.

19 (a) DEC 21 1946 (Date rec'd by Registrar) (b) Evelyn Williams, M.D. Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Dec. 20 1946, at 1:10 M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec. 13 1946, to Dec. 20 1946, and that I last saw her alive on Dec. 17 1946.

Immediate cause of death: Generalized Arteriosclerosis — Duration

Due to Accentuation caused by trauma (fracture femur, left)

Other Conditions

(Includes pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following: 1317
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 12/13/46 at 7 M
(c) Where did injury occur? 3921 Keswick Rd. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Fell while walking in her home.

**23. Signature** A. V. Keedy, M.D. M. D.
Address Union Memorial Hosp. Date signed 12/20/46

For R. John R. Davis, by Howard J. Mullen, M.D.

VS 150

correct age is especially important. Physicians: please write clearly.

G16693

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G16693

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 705 N. Macleira
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 705 N. Macleira
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Caselaby

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W. | Widowed |

6 (b) Name of husband or wife Paul Caselaby
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26/75

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 8 | 22 24 | hr. min. |

9. Birthplace Ceco Slavonia (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name John Jares
13. Birthplace Bohemia

MOTHER
14. Maiden Name Mary Ourka
15. Birthplace Bohemia

16 (a) Informant Joseph Caselaby
(b) Address 705 N. Macleira

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Dec 23/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Undertaker
(b) Address

19 (a) DEC 21 1946 (Date rec'd by registrar) (b) Huntington Wilson Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Dec 19 1946; at 5 H M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Aug. 1946 to Dec 19 1946, and that I last saw h alive on Dec 18 1946.

| Immediate cause of death | Duration |
|---|---|
| Arteriosclerosis generalized | |
| Myocardial Degeneration | 1 year |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis F. Klimes M. D.
Address 2623 E. Monument Date signed 12-21-1946

VS 150

correct age if especially important; physicians: please write clearly and legibly.

G16691

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G16694

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3018 Rockwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3018 Rockwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anna Marie Agne

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| None | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Jacob Agne
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 75 | 11 | 20 | hr. min. |

9. Birthplace Germany (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Louis Obacht
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Blatz
15. Birthplace Germany

16 (a) Informant Mrs Adelyn Dodd.
(b) Address 3018 Rockwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 23, 1946 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Balto. Co.

18 (a) Funeral director J. F. Ellis & Sons
(b) Address Reisterstown, Md.

DEC 21 1946 (Date rec'd by registrar)

(b) Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12-20-46, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-1930, to 12-20-1946, and that I last saw h[er] alive on 1946.

| Immediate cause of death | Duration |
|---|---|
| Myocarditis - | 5 yrs |
| Chronic decompensated | |
| Due to Hypertension | 15 yrs |
| Due to Arteriosclerosis | 15 yrs |
| Other Conditions Cerebral Hemorrhage | 1941 |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James L. Laffell M.D.
Address Reisterstown Md. Date signed 12/20/46

G16695

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. G16695

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1040 N Eden Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1040 N Eden Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James R Ralph

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-5989

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Col | widowed |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 31. 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 1 | 18 | hr. min. |

9. Birthplace Balto Md (Town, county and state)

10. Usual Occupation Out of work

11. Industry or business

FATHER — 12. Name James M Ralph
13. Birthplace Balto Md

MOTHER — 14. Maiden Name Mary E Smith
15. Birthplace Balto Md

16 (a) Informant Bernard Ralph
(b) Address 1309 N Carolina St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem Co
Location Baltimore Co

18 (a) Funeral director Isaiah E Brown Son
(b) Address 1818 Montgomery

19 (a) DEC 21 1946 (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1946, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to June 18 1946, and that I last saw him alive on June 18 1946

Immediate cause of death Cardiac Paralysis (a) Duration complete
Nephritis

Due to

Due to

Other Conditions Chronic Prostatitis

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ralph J Young

Address 1429 E Monument St Date signed 12/20/46

VS 150

G16696

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 186a

Registered No. G16696

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 15
(c) Hospital or institution: West Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 9/16/46
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Moreland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Siegel

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widow |

6 (b) Name of husband or wife Late Abraham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation
11. Industry or business None

FATHER
12. Name Ely Naron
13. Birthplace Russia

MOTHER
14. Maiden Name Unkown
15. Birthplace Russia

16 (a) Informant Julius Siegel
(b) Address 1605 Moreland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec, 22, 1946 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel Cem
Location German Hill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

EC (a) 12 22 1946 (b) Thos Williams M. Registrar
(Date rec'd by registrar)

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/20 1946, at 5:55 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Excussion of Brain

Due to

Other Conditions Arteriosclerotic C.V disease

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/13/46 at about 10:00 P M.
(b) Where did injury occur? 1605 Moreland Ave
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Fell down steps

23. Signature [illegible] M.D. Medical Examiner.
Date signed 12/22/46

G16697

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48B

G16697 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 361-N. Preston St.
(c) Hospital or institution: H

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 361-N. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country no.

**3 (a) FULL NAME** Mary Bell Green

3 (b) If veteran, name war | (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | colored | married |

6 (b) Name of husband or wife George Green
6 (c) If dead, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 6, 1903

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 43 | 11 | 13 | hr. min. |

9. Birthplace Fremount N. C.
(Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name William Carroll
13. Birthplace North Carolina

MOTHER
14. Maiden Name Ella Barnes
15. Birthplace N. C.

16 (a) Informant Rev. George Green
(b) Address 361-N. Preston St.
17 (a) Burial (b) Date thereof Dec 22 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. calvary
Location Cedar Hill Md.
18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill ave.
19 (a) (b)
(Date rec'd by registrar) Registrar

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**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 19 1946, at 9:28 M
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3, 1946 to Dec 20 1946 and that I last saw h alive on Dec 19 1946.

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | 1 yr |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. H. Watts M. D.
Address 515 Walbrook Date signed 12/20/46

X

G16698

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G16698 Registered No. 131 B

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 21 E. Hill St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 y
(e) Length of stay in Baltimore (yrs., mos., or days) 30

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 21 E. Hill St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Janine Ackerman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Isaac Ackerman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 61 | Months Russia | Days | If less than one day hr. min.

9. Birthplace (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name —
13. Birthplace Russia

MOTHER 14. Maiden Name —
15. Birthplace Russia

16 (a) Informant Isaac Ackerman
(b) Address 21 E. Hill St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-46 (month) (day) (year)
(c) Cemetery or crematory Nelson Memory Park
Location

18 (a) Funeral director Isaac Levine Inc
(b) Address 1739 E. Balto St

19 (a) (b) Registrar
(Date rec'd by registrar)

Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20 1946, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1946 to Dec 20 1946 and that I last saw h. alive on Dec 19 1946.

Immediate cause of death: Coronary Thrombosis

Due to: Chronic Myocarditis Nephritis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

| Duration |
|---|
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Svamsdien Jr M. D.
Address 1746 Sea V Date signed 12/27/46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G16699

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G16699

Registered No. 108

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial

(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 628 St. Annes Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Earl J. McCullough

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 46 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Baltimore Co., Md.
(Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business Automobile

FATHER
12. Name Charles McCullough
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary
15. Birthplace Maryland

16 (a) Informant Carroll M. McCullough
(b) Address 628 St. Annes Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 23, 1946 (month) (day) (year)

(c) Cemetery or crematory Middletown
Location Eklo, Baltimore Co. Md.

18 (a) Funeral director Roland L. Fisher
(b) Address 2112 Dundalk Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 12-20 1946, at 8 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Life death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Lobar Pneumonia

Due to

Other Conditions Fatty degeneration of liver, Hypertrophy & Dilatation of Heart
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 12-21-46

VS 151

G16700 G16700

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 146B

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 320 E. 27th st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town 320 E. 27th St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie C. Schluderberg

3 (b) If veteran, name war: W

3 (c) Social Security Account No.:

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12th 1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | 0 | 8 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Henry Schluderberg
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Amelia W. Baker
15. Birthplace Balto. Md.

16 (a) Informant Mrs. T. E. Eastwood
(b) Address 3721 Yolando Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/23/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) 46 (Dated r'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20th 1946; at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6 1946, to Dec 20 1946 and that I last saw her alive on Dec 20 1946.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of stomach | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Ephraim M. D.
Address 443 E 25th St Date signed 12-21-46

VS 150

Correct age is especially important. Physicians: please write plainly.

G16701 G16701

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V47c

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga
(c) Hospital or institution:
Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mon.
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3253 E. Balto St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Robert G. Steinbar

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife: Margaret Steinbar
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1903

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 43 | 8 | 12 | hr. min. |

9. Birthplace Bay City, Mich.
(Town, county, and state)
10. Usual Occupation Seaman
11. Industry or business Merchant Marine

FATHER
12. Name Matthew Steinbar
13. Birthplace Bay City Mich.

MOTHER
14. Maiden Name Barbara Siebold
15. Birthplace Michigan

16 (a) Informant Self.
(b) Address

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 12/23/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 21 1946, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1946, to Dec 21 1946 and that I last saw h/ live alive on Dec 20 1946

Immediate cause of death: Bronchogenic Carcinoma of Lung. — Duration: 1 yr ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 9-25-46
Major findings of operation: Ca. of Lung
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William D. Stanley M. D.
Address Mercy Hosp. Date signed 12-24-46

Enter age if under 1 year. Physicians: please write clearly and legibly.

VS 150

G16702 G16703

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1248

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 708 Mc. Henry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. ANNA M. BRAUD

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James H. Braud

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Feb 12 1884

8. AGE: Years 62 | Months 10 | Days 8 | If less than one day: hr. min.

9. Birthplace: Germany (Town, county and state)

10. Usual Occupation: House Wife

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden Name: Anna Ludwig
15. Birthplace: Germany

16 (a) Informant: George E. Engelbach
(b) Address: 716 Mc. Henry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 23 1946 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: City

18 (a) Funeral director: Mr. Mrs. John W. Teufel & Son
(b) Address: 5311 Edmondson Ave

19 (a) 1946 (Date filed by registrar) (b) Registrar

Huntington Williams, MD

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/20 1946, at 1 15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/26 1946 to 12/20 1946, and that I last saw HER alive on 12/20 1946.

Immediate cause of death: PORTAL CIRRHOSIS
ASCITES

Duration: 24 DAYS

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Charles W. Stewart, Jr. M. D.
Address MD GEN HOSPITAL Date signed 12-30-46

VS 150

Birth Certificate

G-65769

G1670s

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V 160c

G1670s

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL V6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 829 S. Oldham Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Schultz

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Wh. | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 21, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | hr. 5 min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Schultz
13. Birthplace Maryland

MOTHER
14. Maiden Name Jessie Mileto
15. Birthplace Pennsylvania

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Dec-23-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Gerrards Hill Rd

18 (a) Funeral director Frank Della Noce
(b) Address 52 N. Wesley St.

19 (a) 1946 (Date rec'd by registrar) Clinton Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 1946, at 6:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 21 1946, to Dec. 21 1946 and that I last saw her alive on Dec. 21 1946

Immediate cause of death: Premature separation of placenta. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Russell Jordan M.D.
Address Johns Hopkins Hospital Date signed 12-21-46

VS 150

X

G16701 G16701

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48B

Registered No.

Please write the cause of death clearly and legibly. Correct age is especially important. Physicians: please write plainly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1926 Mc Culloh St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Corrine Godfrey Queen

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | Colored | married |

6 (b) Name of husband or wife William H. Queen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1899

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 47 | 6 | 11 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Herbert Dyer
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Mary Tolson
15. Birthplace Baltimore, Md

16 (a) Informant Corrine Graham
(b) Address 1021 Bennett Place

17 (a) Burial (b) Date thereof Dec. 22, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) Lexington Williams, Registrar
(Date rec'd by registrar)

DEC 24 1946

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec 17 1946, at 5:00 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec 9 1946, to Dec 17 1946, and that I last saw her alive on Dec 17 1946,

| Immediate cause of death | Duration |
|---|---|
| Metastatic fibrosarcoma | 1 |
| Due to Probable fibrosarcoma of the uterus | |
| Due to | |
| Other Conditions Diabetes Mellitus | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Metastatic fibrosarcoma, Lungs
of autopsy: Liver, Kidney.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature [illegible], Baltimore, Md.
Address University Hosp. Date signed 12-22-46

X

G16705

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

G16705 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 915 E. Preston St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 915 E. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Kathleen Burke Doddoden

3 (b) If veteran, name war | 3 (c) Social Security Account No. ✓

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 5, 1884

8. AGE: Years 62 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thos. P. Burke
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret McGlynn
15. Birthplace England

16 (a) Informant Mrs. Bayley
(b) Address 915 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 23, 1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 E. Biddle St.

19 (a) (Date received by registrar) (b) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 21 1946 at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1946 to Dec 1946 and that I last saw h[illegible] alive on Dec 18 1946

| Immediate cause of death | Duration |
|---|---|
| Metastatic Carcinoma of brain | |
| Due to Carcinoma of breast | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address 5217 Harford Road Date signed 12-21-46

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G16706 Adams G16706

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2652 Boone St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2652 Boone St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James W. Griffin
3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Col | Married |

6 (b) Name of husband or wife Mildred Griffin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 18-1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 3. | - | hr. min. |

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William Griffin
13. Birthplace Va

MOTHER
14. Maiden Name Margaret D
15. Birthplace Va

16 (a) Informant Mildred Griffin
(b) Address 2652 Boone St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. 2. W

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) (b)
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 18 1946 at 2301 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15, 19XX to 12-18, 19XX and that I last saw h[illegible] alive on 12-17-XX19

Immediate cause of death Acute Congestive Heart Insufficiency Failure — Duration 2 days
Due to Hypertension Cardio Renal — 2 yrs
Due to Uremia
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M Alpert Adams, M. D.
Address 239 N Gay St Date signed 12-22-46

VS 150

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B.C. 2-44577
G10707

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 107

G10707
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1925 W. Pratt St.
(c) Hospital or institution:
VD
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1925 W. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Joan Agnes Saffran

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 24 MAR. 46

8. AGE: Years — | Months 8 | Days 27 | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph F. Saffran
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary A. Smith
15. Birthplace Baltimore, Md.

16 (a) Informant Joseph F. Saffran
(b) Address 1925 W. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 29-Dec-46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director F. B. Wisbart & Son
(b) Address 1300 Eutaw Place.

19 (a) 27 1946 (Date rec'd by registrar) (b) Thurlington Willis Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 26 1946, 4:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18 1946 to 12/26 1946 and that I last saw h alive on 12/19 1946

Immediate cause of death: Bronchopneumonia — Duration 2 days

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature Chas D Cahn M. D.
Address 2145 W Balto St Date signed 12/27/46

VS 150

G16708

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G16708 Registered No. 488

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Caton and Wilkens Ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Arbutus
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 Lindsay Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LILLIE O. POPP Lillie O Popp

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife George L. C. Popp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 7 | 13 | hr. min. |

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Kolb
13. Birthplace Germany

MOTHER
14. Maiden Name Virginia Lockner
15. Birthplace Germany

16 (a) Informant Mrs. G. Popp
(b) Address 1315 Lindsay Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 24 Dec 46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director J. B. Shepherd & Son
(b) Address 800 Eutaw Place

19 (a) 12-24-1946 (Date rec'd by registrar) (b) Huntington Williams (Signature)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/21 1946, at 5 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20 1946 to 12/21 1946 and that I last saw h[illegible] alive on 12/21 1946.

Immediate cause of death: Cardiac failure - due to coronary occlusion
Due to (a) Uterine fib.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

| Duration |
|---|
| |
| |
| |
| |
| |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. D. Mentz MD
Address 8 E Lex Date signed 12/22/46 M D

G76729

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1937

Registered No. G76709

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2713 E Biddle St.
(c) Hospital or institution: 8-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2713 E. Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Essie M. Kraft

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Joseph A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1886

8. AGE: Years: 60 | Months: 5 | Days | If less than one day: hr. min.

9. Birthplace: Balto (Town, county, and state)

10. Usual Occupation

11. Industry or business: At Home

FATHER
12. Name: ? Sapp
13. Birthplace: Balto

MOTHER
14. Maiden Name:
15. Birthplace: Balto

16 (a) Informant: Mildred M. Kraft
(b) Address: 2713 E Lafayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 23 46 (month) (day) (year)
(c) Cemetery or crematory: Balto. Cem.
Location: E North Ave

18 (a) Funeral director: Martin W.E. Dippel's Sons
(b) Address: 315 S Ann St

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 23 1946

Huntington Williams M.D.

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Dec 19 1946 at 9:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21, 1946 to Dec. 19, 1946 and that I last saw her alive on Dec. 19, 1946

Immediate cause of death: Coronary Occlusion — Duration: 15 min.

Due to: Cardiovascular Disease (arteriosclerotic) — Unknown

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Philip W. Artigiani M.D.

Address: 2942 E. Fayette St. Date signed 12/21/46

X

G16710

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

Registered No. G16710

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 10 North Madiera St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 North Madiera St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anna Herzig

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No. | No |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | white | Married |

6 (b) Name of husband or wife Frank J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1864

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | 5 | 19 | hr. min. |

9. Birthplace Bohemia - Germany
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Alexander Stadtler
13. Birthplace Germany

MOTHER
14. Maiden Name Katharine ?
15. Birthplace Germany

16 (a) Informant Frank J. Herzig
(b) Address 10 N. Madeira St.

17 (a) buried (b) Date thereof 12/24/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baker Rd.

18 (a) Funeral director M. W. E. Dippel's Sons
(b) Address Lombard & Ann Sts.

19 (a) DEC 22 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** December 21, 1946, at 6 30 A.M.

**21.** I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Rest death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mendelsohn M.D.
Medical Examiner.
Date signed 12-21-46

P.C. 2-65516

G16711

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 160a

G16711 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. of Baltimore 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County 1
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 262 Spring Court
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Demeduke

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 | 18 | 46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 3 | hr. min. |

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Walter Demeduke
13. Birthplace Camden, N. J.

MOTHER 14. Maiden Name Vera Kasperk
15. Birthplace Camden, N. J.

16 (a) Informant Walter Demeduke
(b) Address 262 Spring Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/46 (month) (day) (year)
(c) Cemetery or crematory St. Joseph's Roman Catholic Cemetery
Location B. & O. Co.

18 (a) Funeral director Chas. P. Dill
(b) Address 1501 E. Fort Ave.

19 (a) 27 1946 (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Dec. 21 19 46, at 6 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 20, 19 46, to Dec. 21 19 46 and that I last saw h alive on Dec. 21 19 46

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Intracranial Hemorrhage Subdural Hemorrhage? | |
| Due to Birth injury | |
| Other Conditions Fract. of L. temporal Hemorrhage into R. Adrenal (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney Green M. D.
Address Hospital Date signed 12/31/46

VS 150

G16712

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1000

Registered No. G16712

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 706 N. PARRISH Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706 N. PARRISH Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Murray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1887

8. AGE: Years 58 | Months 11 | Days 21 | If less than one day ____hr. ____min.

9. Birthplace BALTIMORE, MARYLAND (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name William Murray
13. Birthplace Arundel County, Maryland

MOTHER
14. Maiden Name Julia Middleton
15. Birthplace Frederick, Maryland

16 (a) Informant Walter Murray
(b) Address 1507 W. Franklin Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Lebanon
Location Balto. Co.

18 (a) Funeral director Samuel W. Sullivan & Son
(b) Address 1011 N. Arlington Ave

DEC 23 1946 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 3

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** December 20 1946, at 7:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-7 1946, to 12-20 1946, and that I last saw him alive on 12-19 1946.

| Immediate cause of death | Duration |
|---|---|
| Embolism | Day |
| Due to Varicosed Veins | Several weeks |
| Due to Secondary Anemia | Several weeks |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard H. Hunt M. D.
Address 1607 W. Mulberry St. Date signed 12-21-46

X

713 BC# G 62620

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 157E

Registered No. G36713

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1736 Webster St DOA
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 Hr
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1736 Webster St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Brian Wayne Lacer) Bryan Lacer Correction of Name Webster approved by Dr. C.J.L

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 14th 1946

8. AGE: Years | Months: 6 weeks | Days: 1 d | If less than one day ____ hr. ____ min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name: Earl F. Lacer
13. Birthplace: Balto. Md.

MOTHER 14. Maiden Name: Agnes Timbs
15. Birthplace: Balto. Md.

16 (a) Informant: Earl F. Lacer
(b) Address: 1736 Webster St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/24/46 (month) (day) (year)
(c) Cemetery or ~~crematory~~: Loudon Park
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

19 (a) DEC 23 1946 (Date rec'd by registrar) (b) Huntington Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/22 1946, at 6:29 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Congenital Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Lodrinski M.D.
Medical Examiner.
Date signed 12/22/46

VS 151

G16714

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46B

Registered No. G16714

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 844 N Patterson Park Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 844 N Patterson Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Sarah Braverman

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Late Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | | | hr. min. |

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Hyman Simon
13. Birthplace Russia

MOTHER
14. Maiden Name Unkown
15. Birthplace Russia

16 (a) Informant Herman Braverman
(b) Address 3320 Shelburne Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof D c, 23, 194(illegible) (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Dec 23 1946 (b)
(Date received by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 1946 at 1.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/21 1946 to 12/22 1946 and that I last saw HER alive on 12/21 1946

| Immediate cause of death | Duration |
|---|---|
| CARCINOMA OF STOMACH Metastatic Carcinoma of the LIVER AND PERITONEUM | 2 YRS 1 YR |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John H. Hirschfelder M.D.
Address 6919 Harford Rd Date signed 12/22/46

VS 150

Huntington Williams, M.D.

G16715

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 194a

G16715 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3453 Cottage Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3453 Cottage Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Samuel Topel

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Belle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 7 | 7 | hr. min. |

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business Shoemaker

FATHER
12. Name Solomon Topel
13. Birthplace Russia

MOTHER
14. Maiden Name Baila Winterman
15. Birthplace Russia

16 (a) Informant Hyman Topel
(b) Address 3453 Cottage Ave.

17 (a) Burial (b) Date thereof Dec 23/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mickro Kodesh Cong Cemt.
Location Herring Run

18 (a) Funeral director SOL LEVINSON & BROS.
(b) Address 1124-26 W. North Ave.

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 191 DEC 23 1946

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/22 1946, at 5th A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. P. Sobieski M.D.
Medical Examiner.
Date signed 12/22/46

16716

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 463

G16716

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Texas (b) County
(c) City or town Galveston
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2315 Avenue J (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Tyler, Edward Hayward

3 (b) If veteran, name war

3 (c) Social Security Account No. 422-03-0171

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1910

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 36 | 8 | 9 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Boatman
11. Industry or business Seafarer

FATHER
12. Name Daniel Tyler
13. Birthplace Maryland

MOTHER
14. Maiden Name Nellie Daffin
15. Birthplace Maryland

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-46 (month) (day) (year)
(c) Cemetery or crematory Loyola Russ Catholic Cemetery
Location Baltimore Md.

18 (a) Funeral director John Furnell Home Inc.
(b) Address 403 E. 25th St.

DEC 23 1946 (Date rec'd by registrar) Huntingtown, Williamsport, Md. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 20 1946, at 8:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 16 1946 to Dec. 20 1946, and that I last saw h im alive on Dec. 20 1946

Immediate cause of death Carcinoma of stomach — Duration UNKNOWN

Due to

Due to

Other Conditions Bronchiectasis — UNKNOWN

(Include pregnancy within 3 months of death)

Date of operation ?

Major findings of operation: Gastrojejunostomy prior to admission here

of autopsy: As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed

Correct age is especially important. Physicians: please write plainly.

VS 150

X

G16717

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46

G16717 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto.
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2400 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** SAMUEL OLINER

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | W |

6 (b) Name of husband or wife LYDIA
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 8, 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 10 | 13 | hr. min. |

9. Birthplace NEW YORK (Town, county, and state)
10. Usual Occupation PRODUCE DEALER
11. Industry or business

FATHER
12. Name JOSEPH
13. Birthplace RUSSIA

MOTHER
14. Maiden Name KATE
15. Birthplace RUSSIA

16 (a) Informant HOSPT. RECORDS
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-23-46 (month) (day) (year)
(c) Cemetery or crematory HEBREW FRIENDSHIP
Location E. BALTO. ST

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO. ST

19 (a) (Date filed by Registrar) (b) Registrar

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 21 December 1946 at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 Nov. 1946 to 21 Dec 1946 and that I last saw h[illegible] alive on 21 Dec 1946.

| Immediate cause of death | Duration |
|---|---|
| Circulatory Failure | |
| Due to Generalized Carcinomatosis | |
| Due to | over |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy Generalized Carcinomatosis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ernest Scher
Address Sinai Hospital Date signed 27 Dec 46

G16718 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G16718

# CERTIFICATE OF DEATH ✓ 83a

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3402 Auchentorly Terrace
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto - 3402 Auchentorly Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Isaac Hartman

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Delivah -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | | | hr. min. |

9. Birthplace Riga Latvia (Town, county, and state)
10. Usual Occupation Ret.
11. Industry or business

| | |
|---|---|
| FATHER | 12. Name Samuel - |
| | 13. Birthplace Latvia |
| MOTHER | 14. Maiden Name Rueda - |
| | 15. Birthplace Latvia |

16 (a) Informant Delivah Hartman
(b) Address 3402 Auchentorly Terrace
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-46 (month) (day) (year)
(c) Cemetery or crematory Mair Israel
Location Forest Park Ave
18 (a) Funeral director Jack Levin Inc
(b) Address 1739 E. Balto St
19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 DEC 23 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 1946; at 8 P. M.
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1946, to Dec 22 1946, and that I last saw h[im] alive on Dec 21 1946.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 5 days |
| Due to Arteri-sclerosis | ? |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Frank Lemmen M. D.
Address 8004 Liberty Rd Date signed 12/22/46

Burial Permit Issued

X

G16719 BALTIMORE CITY HEALTH DEPARTMENT G16719

# CERTIFICATE OF DEATH 50

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1312 N. Broadway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** IDA CATHERINE LANTZ

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F. | W | Single |

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) August 5, 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 4 | 14 | hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Peter Lantz
13. Birthplace Germany
14. Maiden Name Catherine Wienecke
15. Birthplace Germany

16 (a) Informant Miss Naomi Lantz
(b) Address 1312 N. Broadway

17 (a) Burial (b) Date thereof 12-23-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (b)
(Date rec'd by registrar) (Registrar)

DEC 23 1946

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 18 1946 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944 to Dec 19 1946
and that I last saw h alive on 19

| | Duration |
|---|---|
| Immediate cause of death Epileptic Convulsion | 1 day |
| Due to Epilepsy | yrs |
| Due to Cerebral Irritation | yrs |
| Other Conditions Laborious Circumspection | 2 yr |
| (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation: —
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —
23. Signature A. T. Rees M. D.
Address 24 S. Monroe Date signed Dec 24/46

G16730 BALTIMORE CITY HEALTH DEPARTMENT G16730

# CERTIFICATE OF DEATH 46 B

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4707 Gunther Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4707 Gunther Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PETER GEORGE ERDMAN, Jr.

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1872

8. AGE: Years 74 | Months 3 4 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore County (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Peter George Erdman, Sr.
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Letitia Waddell
15. Birthplace Baltimore County, Md.

16 (a) Informant Mr. George T. Mumma
(b) Address 4707 Gunther Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/46 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

DEC 23 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 1946, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1946, to Dec. 20 1946, and that I last saw him alive on Dec. 17 1946

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of stomach | 5 yrs |
| Due to | |
| Due to | |
| Other Conditions: Cachexia, Arteriosclerosis, Chronic myocarditis, Blindness (Optic atrophy) | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. V. Harbold, M.D.
Address 4706 Harford Road Date signed 12/21/46

Correct age is especially important. Physicians, please write plainly.

G16721

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G16721 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1721 Hanover
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 Hanover Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Amelia D. FLAMM

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Wm. T. Flamm
6 (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 4 | 16 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name George H. Harzbergen
13. Birthplace Germany

MOTHER
14. Maiden Name Wadgarine Gernert
15. Birthplace Germany

16 (a) Informant Wm. T. Flamm (Husband)
(b) Address 1721 Hanover St. Balto.

17 (a) Burial (b) Date thereof Dec. 23 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem.
Location Anne Arundel Co., Md.

18 (a) Funeral director P. Howard Evans
(b) Address 1400 E. Chase St. Balto 30, Md.

19 (a) (b) Huntington Whitehall, M.D. Registrar
(Date rec'd by registrar)

DEC 28 1946

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 20, 1946, at 9 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Rest death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic heart disease
Obesity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 12/20/46

7,28

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1946

Registered No. 67722

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5008 Morello Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 53 Yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town 5008 Morello Rd
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Laurence E McCalley Sr

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Caroline M McCalley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1 1892

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 | 5 | 21 | hr. min. |

9. Birthplace Washington DC
(Town, county, and state)

10. Usual Occupation
11. Industry or business Electrical Supplies

FATHER
12. Name Robt G McCalley
13. Birthplace Virginia

MOTHER
14. Maiden Name Annie C Watts
15. Birthplace Baltimore Md

16 (a) Informant Mrs L E McCalley Sr
(b) Address 5008 Morello Road

17 (a) Burial (b) Date thereof 12/26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Md

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd Balto 6 Md

19 (a) DEC 23 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 22 1946 19 at 1.00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 9 1946 to Dec 22 1946 and that I last saw him alive on Dec 19 1946

Immediate cause of death: Coronary Thrombosis — Duration: Sudden
Due to: Hypertensive-arteriosclerotic heart disease
Due to:
Other Conditions: Angina pectoris
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. V. Harbold M. D.
Address 4706 Harford Road Date signed 12/27/46

X

VS 150

G167123 BALTIMORE CITY HEALTH DEPARTMENT G167123
# CERTIFICATE OF DEATH 589 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2903 Hudson St.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2903 Hudson St. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Arthur J. Burkhouse

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | white | married |

6 (b) Name of husband or wife Anna H. Burkhouse
6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) March 6 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | 9 | 14 | hr. 18 min. 45 |

9. Birthplace Pittsburgh Pa. (Town, county, and state)
10. Usual Occupation foreman
11. Industry or business Bethlehem Steel

FATHER
12. Name William H Burkhouse
13. Birthplace Scranton Pa.

MOTHER
14. Maiden Name Victoria Yecko
15. Birthplace Pittsburgh Pa.

16 (a) Informant Anna H Burkhouse
(b) Address 2903 Hudson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Duda
(b) Address 2826 Hudson St.

19 (a) DEC 23 1946 (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 8

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-20-46, at 4:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12 1945 to 12-20 1946, and that I last saw h[illegible] alive on 12-20-46.

Immediate cause of death

| | Duration |
|---|---|
| Acute Rheumatic Fever | 1935 |
| Rheumatic Pancarditis | 8-12-45 |
| Due to Myocardial Failure | 12-8-46 |
| Due to | |
| Other Conditions None | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emil Schmunk M. D.
Address 1741 Eutaw Pl Date signed 12-21-46

X

G16721

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G16724 Registered No.

**1. PLACE OF DEATH:** D.O.A.
(a) Baltimore City, Maryland
(b) Street address 211 N. Milton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 61
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 N. Milton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Carrie Bennett

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| — | — |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | married |

6 (b) Name of husband or wife Edw. Bennett
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Dec 28, 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 11 | 25 | ____ hr. ____ min. |

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Fred Weinrich
13. Birthplace Germany

MOTHER
14. Maiden Name Dora Lenke
15. Birthplace Germany

16 (a) Informant Frederick Weinrich
(b) Address 211 N Milton Ave

17 (a) Burial (b) Date thereof Dec 24th
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location Balt City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 23 1945

VS 151

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 12/22 1945, at 12:30 P.M.

**21.** I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ____ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

**IMMEDIATE CAUSE OF DEATH**
Chronic Valvular Heart Disease
Due to
Other Conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 12/22/45

937

G167,35

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1946

Registered No. G167,35

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 666 W. Fayette St
(c) Hospital or institution:
University Hosp. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dor.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 665 West Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** George Keck

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife India Keck

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Don't Know

8. AGE: Years 65 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business

FATHER
12. Name Wm Keck
13. Birthplace Balto

MOTHER
14. Maiden Name Berdina Buttermeier
15. Birthplace Balto

16 (a) Informant India Keck
(b) Address 2022 Orleans St

17 (a) Burial (b) Date thereof Dec 23
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 181

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 19, 1946; at 2:10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Ulrich M.D.
Medical Examiner.
Date signed 12-19-46

DEC 23 1946

X

G167326

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G167326

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts
(c) Hospital or institution:
Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3d
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yr

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 377 Eastern Ave (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

**3 (a) FULL NAME** Joseph Grimes

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | D |

6 (b) Name of husband or wife Mrs. Joseph Grimes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 9 10 | 20 14 | hr. min. |

9. Birthplace Delaware (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name James Grimes
13. Birthplace Delaware

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant above
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Gorsuch Gate
18 (a) Funeral director John E. Hilton
(b) Address 4261 Greenmount Ave
19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 22 1946, at 325 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 12-20 1946 to 12-22 1946, and that I last saw him alive on 12/22 1946.

| Immediate cause of death | Duration |
|---|---|
| Resp. Failure | |
| Due to Heart failure | |
| Due to Coronary H. D. is | |
| Other Conditions Hemolaurosis | |

(Includes pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....
23. Signature James V Mason M. D.
Address Mercy Hosp Date signed 12/24/46

DEC 23 1946 Huntington Williams, M.C.

X

Please write correct age in especially important. Physicians: please write clearly and legibly.

G16727

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

Registered No. G16727

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3711 Chatham Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3711 Chatham Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** CORNELIUS ALFRED WATKINS

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| None | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Laura Rebecca Watkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 7 | 5 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business International Harvester Co.

FATHER
12. Name Lorenzo Dallas
13. Birthplace Md.

MOTHER
14. Maiden Name Jane D. Purdum
15. Birthplace Md.

16 (a) Informant Mrs. C. A. Watkins- Wife
(b) Address 3711 Chatham Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/46 (month) (day) (year)
(c) Cemetery Upper Seneca
Location Cedar Grove, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 (a) Dec 23 1946 (Date rec'd by registrar) (b) Williamsport Md. Registrar

V S 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec. 20, 1946 19..., at 8:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 16 1946 to Dec 20 1946. and that I last saw h[illegible] alive on Dec 20 1946.

| Immediate cause of death | Duration |
|---|---|
| Arteriosclerotic Cardio-Vascular disease | 1 year |
| Due to | |
| Due to | |
| Other Conditions Terminal bronchopneumonia (Include pregnancy within 3 months of death) | 4 days |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clarence F. Carter M. D.
Address 11 E. Chase Street Date signed Dec 24, '46

X

G16728 BC# BALTIMORE CITY HEALTH DEPARTMENT ✓ G16728

D22936 CERTIFICATE OF DEATH 13 B Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Caton and Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4620 Curtis Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Christine Ramey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1945

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 1 | 8 | 28 | hr. min. |

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Walter Ramey
13. Birthplace W. Va.

MOTHER 14. Maiden Name Annie Robinson
15. Birthplace Virginia

16 (a) Informant Walter G. Ramey
(b) Address 4620 Curtis Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) 12/22/46
(c) Cemetery or crematory Cedar Hill
Location Baltimore, Md.

18 (a) Funeral director Harry A. Whitaker
(b) Address 401 Edmondson Ave

19 (a) (Date received by registrar) (b) Whitaker-Wilson Hospital

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 12/19 1946, at 7:28 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 12/16 1946, to 12/19 1946, and that I last saw h[illegible] alive on 12/17 1946.

Immediate cause of death: Cardiac failure - Tuberculous pneumonia - Miliary

| | Duration |
|---|---|
| Due to: Tuberculosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23.** Signature D.W. Mintz M.D.
Address 4 Wayne Haza Date signed 12/19/46

G167,29

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

G167,29 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 899 N. Howard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 899 N. Howard St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Samuel Levy.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Viola Levy.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1891.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | 1 | 17 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Grocery & Liquor Dealer
11. Industry or business

FATHER
12. Name Albert Levy,
13. Birthplace Austria.

MOTHER
14. Maiden Name Johanna Benesch,
15. Birthplace Austria.

16 (a) Informant Mr. Julius Levy,
(b) Address 897 N. Howard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12. 23, 46. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Baltimore, Md.

18 (a) Funeral director Harold Lerner and Associates
(b) Address 1902 Eutaw Place.

19 (a) DEC 23 (Date received by registrar) (b) 1946 Registered by Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 21st. 1946 at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1945 to Dec. 21 1946 and that I last saw h[illegible] alive on Dec. 18 1946.

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | 1 or 2 hrs. |
| Due to Arteriosclerosis | |
| Due to | |
| Other Conditions Hypertension | 10 yrs + |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. Murray Fisher
Address 18 E. Eager St. Date signed 12/30/46

VS 150

Correct age is especially important. Physicians please write plainly.

G16730 ✓ G16730

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46a

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2613 Liberty Heights Ave.
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2613 Liberty Heights Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** FRANCES FULD.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Solomon Fuld. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 14, 1878.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 9 | 8 | hr. min. |

9. Birthplace Germany. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Wolf Ronsheim,
13. Birthplace Germany.

MOTHER
14. Maiden Name Taubchen Schoeneman,
15. Birthplace Germany.

16 (a) Informant Mr. Melvin Fuld,
(b) Address 2303 Ocalo Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12.24.46 (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Levine & Son
(b) Address 1902 Eutaw Place.

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 22, 1946 19 , at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1941, to Dec 22 1946, and that I last saw h ve alive on Dec 1 19 46

Immediate cause of death: Carcinoma of esophagus — Duration: 3 months

Due to

Due to

Other Conditions Pernicious Anemia — 5 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alan Bernstein M. D.
Address 1109 N. Calvert St Date signed 12-23-46

VS 150

Burlington Hotel, Balto, Md.

Dec 23 1946

X

G16731

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1218

Registered No. G16731

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 407 N. East Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-10
(e) Length of stay in Baltimore (yrs., mos., or days) 45yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 407 N. East Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Arthur H. Valke

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| -- | 213-05-5086 |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Mary Marie Valke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1897

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 49 | 0 | 15 | hr. min. |

9. Birthplace Wash. D.C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Arthur Valke
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Reimer
15. Birthplace Germany

16 (a) Informant Mrs. Mary Marie Valke
(b) Address 407 N. East Ave.

17 (a) Burial (b) Date thereof Dec. 23/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto. Md.

18 (a) Funeral director Philip Herwig & Sons
(b) Address 2024 Orleans St.

19 (a) (Date rec'd by registrar) DEC 23 1946 (b) Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 20/46 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1946 to Dec 20 1946 and that I last saw h. alive on Dec 20 1946.

Immediate cause of death Hemorrhage of Brain, Duration 1 day

Due to Chronic Brights Disease of Kidneys 2 yr

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur C. Heagy M. D.
Address 3701 Garrison Blvd Date signed 12/23/46

Correct age is especially important. Physicians: please write plainly.

VS 150

G16732

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

92 B

Registered No. G16732

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St;
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 Reistertown Rd.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** Henry, James Wallace

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| WWI | — |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 11 | 5 | hr. min. |

9. Birthplace Fresno Co. Cal.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name James Henry
13. Birthplace Calif.

MOTHER
14. Maiden Name Mary Wallace
15. Birthplace Calif.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24 1946 (month) (day) (year)
(c) Cemetery or crematory National
Location Frederick Ave

18 (a) Funeral director [illegible]
(b) Address [illegible]

19 (a) (Date rec'd by registrar) (b) [illegible] Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 20 1946 at 3:05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 1946 to Dec. 20 1946 and that I last saw him alive on Dec. 20 1946

Immediate cause of death (1) Post operative state, amputation Mid Lower extremity for embolism right
Due to femoral artery
(2) Mitral stenosis
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature V. J. Donner M.D.
Address U.S. Marine Hospital Date signed 12/29/46

Correct age is especially important. Physicians, please write in ink.

DEC 23 1946

Form 150

G16733

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 940

G16733
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 319 W. 27th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John T. Cross

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Ida W. Cross
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 8 | 3 | hr. min. |

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Joshua Cross
13. Birthplace Md.

MOTHER
14. Maiden Name Elling Streakens
15. Birthplace Md.

16 (a) Informant Mamie V. Langley
(b) Address 319 W. 27th st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Kenneth V. Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) DEC 23 1946 (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 21 1946, at 10:15 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Dec death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary disease
Generalized advanced athero-
Duration sclerosis. Acute pulmonary
edema.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 12-21-46

VS 181

G16734

G16731

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1242

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts
(c) Hospital or institution Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Clarence R. Hale.

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-16-5827

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Mabel Hale
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30, 1898

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 48 | 8 | 21 | hr. min. |

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business

FATHER
12. Name George H. Hale.
13. Birthplace Md.

MOTHER
14. Maiden Name Annie M. Hale.
15. Birthplace Md

16 (a) Informant Mrs Katie V. Neal.
(b) Address 239 Powers St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 23 1946 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto County.

18 (a) Funeral director Hepworth & Donovan.
(b) Address 1615-17 Eastern Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 200

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 20 1946, at 8:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1946, to Dec 20 1946, and that I last saw him alive on Dec 20 1946.

| Immediate cause of death | Duration |
|---|---|
| Hemorrhage | 1 d |
| Due to Esophageal Varices | 5 yrs |
| Due to Cirrhosis of Liver | 5 yrs |
| Other Conditions Possible pulmonary tuberculosis | 2 y |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward H. Santmeier, M. D.
Address Franklin Sq. Hosp Date signed 12/26/46

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G46735

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G46735

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3509 Harford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 719 S. Fagley Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

**3 (a) FULL NAME** Charles A. Manley

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | married |

6 (b) Name of husband or wife Thelma
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 5/8/15

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 31 | 7 | 11 | hr. min. |

9. Birthplace Defiance, Penna (Town, county, and state)
10. Usual Occupation Mechanic
11. Industry or business

FATHER
12. Name Chas. N. Manley
13. Birthplace Pa.

MOTHER
14. Maiden Name Nannie Dale
15. Birthplace Pa.

16 (a) Informant Thelma Manley (wife)
(b) Address 719 S. Fagley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Lilly & Zeiler Dr
(b) Address 403 S. Wolfe Street Huntington Williams, M

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 23 1946

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 19 1946, at 1:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 1946 to Dec 19 1946, and that I last saw him alive on Dec 19 1946

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | 1 hr |
| Due to — | |
| Due to — | |
| Other Conditions — | |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature Chas. Zimmerman M.D.
Address 2854 Harford Ave Date signed 12/22/46

G16736

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1063

Registered No. G16736

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 815 S. Eaton Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 815 S. Eaton Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** James L. Gillease

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 / 14 / 75

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 10 | 5 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business D.S.C. Balto. City

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Vincent F. Gillease ( son)
(b) Address 815 S. Eaton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Avenue

18 (a) Funeral director Tilly & Zeiler Inc.
(b) Address 403 S. Wolfe Street

19 (a) Dec 23 1946 (Date rec'd by registrar) (b) Hunting for Williams Registrar

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 19, 1946 at 6:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1943 to Dec. 19, 1946, and that I last saw him alive on Dec. 19, 1946

| Immediate cause of death | Duration |
|---|---|
| Chronic bronchitis | 3 years |
| Due to Arterio-sclerosis | over 3 " |
| Due to Myocardial insufficiency | 3 days |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. Benedict Bromuskas, M.D.
Address 3037 O'Donnell St Date signed DEC 21 1946

AB- 106789 G16737

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

939

Registered No. G16737

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9days
(e) Length of stay in Baltimore (yrs., mos., or days) 7yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 500 S. Highland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Henry Sauer

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | ? |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | White | Widower |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8- 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 0 | 12 | hr. min. |

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name Conrad ?
13. Birthplace Germany ?

MOTHER
14. Maiden Name Barbara ?
15. Birthplace Germany ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn.
Location Eastern Ave.

18 (a) Funeral director John P. Connelly.
(b) Address 414 Eastern Ave. Essex

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 20- 19 46, at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-11 19 46, to 12-20 19 46, and that I last saw h- im alive on 12-20 19 46.

Immediate cause of death: Peripheral circulatory collapse — Duration
Due to: Arteriosclerotic cardio-
Due to: vascular disease.
Other Conditions: Amputation right lower leg — imminent arteriosclerotic gangrene
(Include pregnancy within 3 months of death)
Date of operation 12/18/46
Major findings of operation: Markedly sclerotic femoral & popliteal artery
of autopsy: O

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature
Address Baltimore City Hospitals Date signed 12/21/46 M D

VS 150

X

G16738

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 92D

G16738 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1745 Belt St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1745 Belt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary A. Flynn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F. | W. | S. |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 25. 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 11 | 5 | hr. min. |

9. Birthplace Phila. Pa.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Michael J. Flynn
13. Birthplace Ireland.

MOTHER
14. Maiden Name Catherine Sands
15. Birthplace Ireland.

16 (a) Informant Nellie Flynn
(b) Address 1745 Belt St.

17 (a) Burial (b) Date thereof 12-24-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1476 Light St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar
DEC 28 1946

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 12/20 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1946, to Dec 20 1946, and that I last saw h[illegible] alive on Dec 20 1946.

| Immediate cause of death | Duration |
|---|---|
| Chronic Endocarditis | 2 mo. |
| Due to — Arterio Sclerosis | 6 mo. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address 1279 Hillsdale Date signed 12/24/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G16739

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 77E

G16739 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1808 Park Avenue
(c) Hospital or institution: 13

D.O.A.

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 Park Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** SUSAN H. WHITE

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Divorced |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1909

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 39 | 5 | 6 | hr. min. |

27

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business -

FATHER
12. Name James W. Harry
13. Birthplace Pylesville, Md.

MOTHER
14. Maiden Name Elizabeth B. Eyerly
15. Birthplace Hagerstown, Md.

16 (a) Informant Mrs. Elizabeth E. Harry
(b) Address 1808 Park Ave.

17 (a) Burial Cremation (b) Date thereof 12/23/46
(Burial, cremation, or removal) (month) (day) (year)
(c) ~~Cemetery~~ or crematory Greenmount
Location Leo J. Tuckner & Sons

18 (a) Funeral director
(b) Address

19 (a) (Date received by registrar) (b) Wilmington Registrar

VS 181

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22, 1946, at 9 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary edema

Due to Alcoholism

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12-23-46

G16710

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13B

G16710 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 954 Forrest St.
(c) Hospital or institution Maryland Penitentiary Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 ?
(e) Length of stay in Baltimore (yrs., mos., or days) ?

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Anne Arundel
(c) City or town Fairfield (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Vanlandingham

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-94-14112

4. Sex Male | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Blanche Vanlandingham

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 11 27 1921

8. AGE: Years 25 | Months ✓ | Days 23 | If less than one day hr. min.

9. Birthplace Fairfield, Md (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Samuel Vanlandingham
13. Birthplace Winston Salem, N.C.

MOTHER
14. Maiden Name Marie Green
15. Birthplace Winston Salem, N.C.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24-1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A. A. Co. Md.

18 (a) Funeral director Robt E. Fiddaman
(b) Address 1615 Mordecai Ave

(Date received by registrar) (b) Registrar
Huntington Williams, M.D.

VB 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 20 1946, at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1946, to Dec. 20 1946, and that I last saw him alive on Dec. 20 1946.

Immediate cause of death: Tuberculous meningites — Duration
Due to: Pulmonary tuberculosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Aubrey
Address 954 Forrest St Date signed 12-28-46

X

# HEALTH DEPARTMENT—CITY OF BALTIMORE

G16711 — 97 — G16711

## CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 E. 23rd St. | 4-1 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Margaretta Constance Cooley — If U. S. Veteran specify WAR

(a) Residence: No. 723 W. North Ave. St., Ward.
(Usual place of abode) (If non-resident give city or town, and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. Color or Race | 5. Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| female | white | single |

6a. If married, widowed, or divorced: HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) May 20, 1872

| 7. AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 74 | 7 | 1 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) England

FATHER

13. NAME James H. Cooley

14. BIRTHPLACE (city or town) (State or country) England

MOTHER

15. MAIDEN NAME Margaretta ?

16. BIRTHPLACE (city or town) (State or country) England

17. INFORMANT Mrs. Leonard B. Johnson

(Address) 1811 Thomas Ave.

18. BURIAL, CREMATION OR REMOVAL

Place Loudon Park Cem. Date 19

19. UNDERTAKER John A. Mitchell & Sons, Inc.

(Address) 1600 Eutaw Place

20. FILED 23 1946 Huntington Williams, Registrar.

### MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Dec 21, 1946

22. I HEREBY CERTIFY, That I attended deceased from Dec 17, 1946 to Dec 21, 1946

I last saw h[er] alive on Dec. 20 1946 Death is said to have occurred on the date stated above, at 7.45 Am.

The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Arteriosclerosis | |
| Cardiac failure | |
| Arrested by Intervention | |

Other contributory causes of importance

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, when?

(Signed) Harvey B. Beck M. D.

(Address) 100 E 23rd St.

VS 3

Harvey B. Beck X

G16712

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 55E

Registered No. G16712

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 203 St. Johns Rd Apt 10 (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Edward Harris Mealy

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | |

6 (b) Name of husband or wife Mrs. Mary M. Mealy
6 (c) If alive, give age yrs.

7. Birth date of deceased (mo., day, yr.) Aug 17 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 4 | 5 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Manufacturer
11. Industry or business

| | |
|---|---|
| 12. Name | Mr. John W. Mealy |
| 13. Birthplace | Maryland? |
| 14. Maiden Name | Ella Harris |
| 15. Birthplace | Canada |

16 (a) Informant Mrs. Mary M. Mealy
(b) Address 203 St. Johns Rd, Apt 10

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-22-46 (month) (day) (year)
(c) Cemetery Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place
Huntingtown Williamsport, Md.

19 (a) (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 22 1946, at 9:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1946 to Dec 22 1946, and that I last saw him alive on Dec 22 1946

| Immediate cause of death | Duration |
|---|---|
| Coronary occlusion of t.b.a. | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Not done

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Malcolm J. Hunt M. D.
Address Union Memorial Hosp Date signed 12-28-46

correct age is especially important. Physicians: please write plainly.

VS 190

G16713 BALTIMORE CITY HEALTH DEPARTMENT G16713

# CERTIFICATE OF DEATH 77

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3027 Hamilton Ave.
(c) Hospital or institution:
none

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3027 Hamilton Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** William H. Bacon

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Mamie Bacon Pfuff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 6 | 11 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name William Bacon
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Eleanor Stuart
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Mildred Bacon
(b) Address 3027 Hamilton Ave.

17 (a) Burial (b) Date thereof 12/23/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell Undertaking Co., Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1946 to Dec 1946, and that I last saw him alive on Dec 20 1946

| Immediate cause of death | Duration |
|---|---|
| Cardiac decompensation | |
| Due to Coronary Arteriosclerosis | |
| Due to | |
| Other Conditions Chronic Alcoholism | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address 5217 Harford Rd. Date signed 12-22-46

VS 150 Huntington Williams, M.D. 94a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dec 5 1946 BC# G47594

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1579

Registered No. G16724

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3319 Foster Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pamela M. Packer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-11-46

8. AGE: Years | Months: 7 | Days: 11 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harold Packer
13. Birthplace Penn.

MOTHER
14. Maiden Name Felicia Gavellas
15. Birthplace R. I.

16 (a) Informant Ricardo.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-23-46. (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location Herman Hill Rd

18 (a) Funeral director Charles L. Zeiler
(b) Address 3605 Fait Ave.

19 (a) (Date received by Local Registrar) DEC 23 1946 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 1946 at 5 40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12 1946 to Dec 22 19..., and that I last saw her alive on Dec 22 1946.

| Immediate cause of death | Duration |
|---|---|
| CONGENITAL ATRESIA OF BILE DUCTS | LIFE |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul H Harbin M. D.
Address Johns Hopkins Hosp. Date signed 12-22-46

Huntington Hospital

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16715 G16715

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1170 ✓

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 17 N. Gilmore St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) unknown

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 17 N. Gilmore St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Wyatt Wallace

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Col | W |

6 (b) Name of husband or wife Mary Wallace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 60 | 7 | 2 | hr. min. |

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation Handy Man
11. Industry or business

FATHER
12. Name Frank Wallace
13. Birthplace N. C.

MOTHER
14. Maiden Name Nancy Neals
15. Birthplace N. C.

16 (a) Informant Connie Wallace
(b) Address 17 N. Gilmore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 23 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md
18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bentley ave

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12-17- 1946, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-15- 1946, to 12-17- 1946, and that I last saw h[illegible] alive on 12-17- 1946.

Immediate cause of death Myocarditis — Duration unknown
Due to
Due to
Other Conditions gastric ulcer
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mark A. Saunders M. D.
Address 1029 N. Stricker St Date signed 12-19-46

DEC 23 1946

93E

Birth Certificate Baby McLean ✓ G16736

G16736

B-60135

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 122 B

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave.
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2733 St Paul St
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Machael R. Mc Lendon

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Infant

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1946

8. AGE: Years ..... Months ..... Days 8 If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER
12. Name Ernest L. Mc Lendon
13. Birthplace New York

MOTHER
14. Maiden Name Elaine Staum
15. Birthplace Baltimore, Md.

16 (a) Informant Ernest L. Mc Lendon
(b) Address 2733 St. Paul St.

17 (a) Burial (b) Date thereof Dec. 23 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pt. Olivet
Location Frederick Road

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) 12-23-1946 (b) Huntington Willis Registrar
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 1946, at 5 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/15/1946, to 12/22/1946, and that I last saw h[illegible] alive on 12/22/1946.

Immediate cause of death Resp Failure — Duration .....

Due to .....

Due to .....

Other Conditions Intra uterine
Meconium peritonitis ? syst. obs.
(Include pregnancy within 3 months of death)

Date of operation 12/15/46

Major findings of operation: Peritonitis

of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Stanley N. Goffe, M. D.
Address Sinai Hosp. Date signed 12/22

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G16717

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13

G16717 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1414 Mt. Royal Avenue
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 24 Years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 Mt. Royal Avenue
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

**3 (a) FULL NAME** William J. Kelly

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife ----------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) June 5, 1922

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 24 | 6 | 17 | -- hr. -- min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Real Estate

FATHER
12. Name Thomas P. Kelly
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Helen L. Birmingham
15. Birthplace Alleghany Co., Md.

16 (a) Informant Thomas P. Kelly
(b) Address 1414 Mt. Royal Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meads and Son
(b) Address 805 N. Calvert Street

19 (a) ---- (Date received by registrar) (b) ----

DEC 23 1946

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 22 19 46, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1946 to Dec 22 1946, and that I last saw him alive on Dec. 22 1946

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Hemorrhage | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. Nelmes M. D.
Address 701 N. Howard St. Date signed 12/23/46

X

JL - 98788 G16718 BALTIMORE CITY HEALTH DEPARTMENT ✓ G16718

# CERTIFICATE OF DEATH 13B

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 -28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore ✓
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Jessie Brockington

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 21, 1928

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 18 | 8 | 1 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward Brockington
13. Birthplace S. C.

MOTHER
14. Maiden Name Sadie Spiver
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (cremation, or removal) (b) Date thereof 12 26 46 (month) (day) (year)
Cemetery or crematory
Location

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania Ave.

19 (a) [illegible] Huntington-Williams, M.F.H. Registrar
(Date received by registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 1946, 6.45P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 24 1946 to Dec. 22 1946 and that I last saw h alive on Dec. 22 1946

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Tuberculosis, Far Advanced | 1 year |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. H. Bird M. D.
Address Balto City Hosps Date signed 12-23-46

X

G16719 G16719

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

166 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 13 Mths

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 Pennsylvania Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Stephen White

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | SINGLE |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-9-1921

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 25 | 5 | 7 | hr. min. |

9. Birthplace BALTIMORE. Md.
(Town, county, and state)

10. Usual Occupation PORTER

11. Industry or business

FATHER
12. Name SYLVESTER WHITE
13. Birthplace Md.

MOTHER
14. Maiden Name MAZZIE COLLINS
15. Birthplace Md

16 (a) Informant MRS. VIOLA WHITE.
(b) Address 1123 DIVISION ST.

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 12 23-46 (month) (day) (year)
(c) Cemetery or crematory PRINCESS ANN - CEM.
Location PRINCESS ANN. Md

18 (a) Funeral director William C. Jackson
(b) Address 916 Pennsylvania ave

19 (a) (Date rec'd by registrar) (b) Lington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 1946, at 12 P.M. KJ

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of heart, aorta and lungs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-16-46 12:30 A M.
(b) Where did injury occur? New Lincoln Tavern 1005 Pennsylvania Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms

23. Signature Homer J. Cleveden M.D.
Medical Examiner.
Date signed 12-16-46

VS 151

G16750 BALTIMORE CITY HEALTH DEPARTMENT ✓ G16750

# CERTIFICATE OF DEATH 937

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1902 N. Fulton Ave.
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 76 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1902 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** WILLIAM F. COLLETT

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| None | ? |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Lotta M. Collett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 5 | 16 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired Policeman
11. Industry or business

FATHER
12. Name William Collett
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary A. Steimer
15. Birthplace Pa.

16 (a) Informant Mrs. Lotta M. Collett, Wife
(b) Address 1902 N. Fulton Ave.

17 (a) Burial (b) Date thereof 12/24/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Wm. J. TICKNER & SONS INC.
(b) Address North & Pa Aves. Balto. 17, Md.

19 (a) DEC 23 1946 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

V S 190

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20, 1946 19 , at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 15 1946, to Dec 20 1946, and that I last saw him alive on Dec. 20 1946.

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | 12/20/46 |
| Due to Chr. myocardi tis | 1944 |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1663 Mount St Date signed 12/24/46

X

G16751

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 47a

Registered No. G16751

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3509 Windsor Mill Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3509 Windsor Mill Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** WILLIAM EWIN BONN

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | no |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Nettie Hallowell Bonn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 5 | 16 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Attorney
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mr. Robert H. Bonn, son
(b) Address 102 Mt. DeSales Rd.

17 (a) Burial (b) Date thereof 12/24/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Livingston Williams registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 21 1946 at 7 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1942 to Dec 21 1946 and that I last saw h alive on Dec 21 1946.

Immediate cause of death: Cerebral Hemorrhage
Due to Hypertension

| Duration |
|---|
| 3 Months |
| Gradual |

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. F. Roadley M. D.
Address 1403 Park Ave Date signed 12/27/46

V S 190

G16752 BALTIMORE CITY HEALTH DEPARTMENT G16752
CERTIFICATE OF DEATH 170a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 St. Paul Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrel (Carroll) E. Musicle

3 (b) If veteran, name war U.S.N. II

3 (c) Social Security Account No. 218-18-6584

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8th 1924

8. AGE: Years 22 Months 10 Days 13 If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Conductor

11. Industry or business Pa. R. R.

FATHER 12. Name Elegious Musick

13. Birthplace Va.

MOTHER 14. Maiden Name Grace Couch

15. Birthplace Va.

16 (a) Informant Mr. Elegious Musick

(b) Address 10 N. Chester st

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/23/46 (month) (day) (year)

(c) Cemetery or crematory St. Paul

Location Kane Co. Va.

18 (a) Funeral director Philip Harris Sons

(b) Address 2024 Orleans St

(a) (Date rec'd by registrar) (b) Registrar

DEC 23 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21, 1946 at 12 20 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured pelvis, bronchopneumonia, Hemoperitoneum

Due to

Other Conditions Multiple bruise bruises

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 12-18-46 at 2:20 A. 24/2 M.

(b) Where did injury occur? Key highway & Cross Street

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Auto and freight train collision

23. Signature Howard J. Weidler M.D.
Medical Examiner.

Date signed 12/23/46

Hunterstown, Pa.

G16753

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

168

G16753 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7007 Dunmanway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Leo Cavanaugh

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | - | 6 | hr. min. |

9. Birthplace Scranton, Pa.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Cavanaugh
13. Birthplace Scranton, Pa.

MOTHER 14. Maiden Name ?
15. Birthplace England

16 (a) Informant (Mrs. Catherine) Cavanaugh
(b) Address 709 E. 1st., Spanish Pt.

17 (a) Burial (b) Date thereof 12/26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Scranton, Pa.

18 (a) Funeral director John A. Moran
(b) Address 3002 E. Baltimore St.

19 (a) DEC 23 1946 (b)
(Date rec'd by registrar) Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22- 1946 at 12:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shock
Multiple Fractures
Due to

Other Conditions Multiple contusions, Brush Burns + abrasions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/21/46 at 10:10 P.M.
(b) Where did injury occur? 7007 Dunmanway
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Blunt force

23. Signature Howard J. Wheeler M.D.
Medical Examiner.
Date signed 12-23-46

G16754

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

46E

Registered No. G16754

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 2449 Fairmount (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Walter J. Weber

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-07-7191

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | ~~M~~ W |

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) Sept 15-1908

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 38 | 3 | 7 | ..... hr. ..... min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Steel Inspector
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Anthony Weber.
13. Birthplace Poland

MOTHER
14. Maiden Name Anna Brzezinska
15. Birthplace Poland

16 (a) Informant Elizabeth Weber.
(b) Address 2449 Fairmount

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-46 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore Md

18 (a) Funeral director George A. Weber
(b) Address 705 S. Conn st

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

VS 150 DEC 23 1946

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 12-22- 1946 at 10:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22 1946 to 12/22 1946 and that I last saw h. alive on 12/22 1946

| Immediate cause of death | Duration |
|---|---|
| Pulmonary edema | |
| Due to Massive Pulmonary Effusion | |
| Due to Carcinoma of Sigmoid | |
| Other Conditions Colostomy | |

(Include pregnancy within 3 months of death)

Date of operation June 1946
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John B Weber M.D.
Address 46 Jos Bldg Date signed 12-28-46

Correct age is especially important. Registrar should verify.

JL - 72716 G16755

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

937

Registered No. G16755

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 - 8- 27
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** James Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | Married |

6 (b) Name of husband or wife Polly Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 20, ? 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 ? | 0 ? | 27 | hr. min. |

9. Birthplace Harrisburg, Pa. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Carlow Glasshouse

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Charlett Davis
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24 1946 (month) (day) (year)
(c) Cemetery or crematory Mount Hope
Location Baltimore, Md.

18 (a) Funeral director Joseph A. Burly
(b) Address 611 West Lanvale St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 DEC 23 1946 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 18 1946, at 4.10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 21, 1942 to Dec. 18 1946, and that I last saw him alive on Dec. 18 1946.

| Immediate cause of death | Duration |
|---|---|
| Myocardial Failure | |
| Due to Arteriosclerosis | |
| Due to Acute Dilatation | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.
Address Balt. City Hosp. Date signed 12/23/46

G16736 G16736

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

932

Registered No. 16

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Hanover St
(c) Hospital or institution: U. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3108 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA HUNTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | M |

6 (b) Name of husband or wife JOSEPH HUNTER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5 - 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 11 | 15 | hr. min. |

9. Birthplace Balto Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at Home

FATHER
12. Name Henry Wagner
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Fitz
15. Birthplace Germany

16 (a) Informant Mrs Louis Bruns
(b) Address 2029 W Balto St

17 (a) Burial (b) Date thereof 12/23/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Balto Md

18 (a) Funeral director Geo L. Berger Jr.
(b) Address 1512 Holbrook St

19 (a) (b) Hunting Williams M.D.
(Date received by registrar)

DEC 28 1946

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12 | 20 1946, at 2.35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12 | 18 1946 to 12 | 20 1946 and that I last saw h alive on 12 | 20 1946.

Immediate cause of death Cardiac Insuf.
fortune

| Duration |
|---|
| |
| |
| |
| |

Due to Interstitial Myocarditis
Vascular Disease

Due to Bilateral effusion

Other Conditions Hypertrophic arthritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E Rosebery M.D.
Address U. Hosp Date signed 12/23/46

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G16757

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G16757

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3328 Spaulding Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3328 Spaulding Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph F. Tracey

3 (b) If veteran, name war Span-Amer. | 3 (c) Social Security Account No. 216-05-2887

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. widower

6 (b) Name of husband or wife Lottie H. Tracey.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 8, 1877

8. AGE: Years 69 | Months - | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business John B. Tedt.

FATHER 12. Name John H. Tracey

13. Birthplace Maryland.

MOTHER 14. Maiden Name Emma L. ?

15. Birthplace Maryland.

16 (a) Informant Charles A. Tracey.
(b) Address 2712 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 26/46 (month) (day) (year)
(c) Cemetery or crematory Pine Grove
Location Balto Co. Md.

18 (a) Funeral director Chenowet & Donovan
(b) Address 34 15-17 Chestnut Ave

19 (a) DEC 23 1946 (Date received by registrar) (b) Huntington Williams, M.D. (Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 23, 1946, at 6 a. M

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry thereon and from the evidence (Autopsy or Inquiry)
obtained by said Inquiry find that said decedent came (Autopsy or Inquiry)
to his death on the day stated above.

| Immediate cause of death | Duration |
|---|---|
| Arteriosclerotic Cardio-Vascular Disease | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P. Clegg M.D.
Medical Examiner.
Date signed 12/23/46

VS 6

Dr. Peterman
1226 Hanover St.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 463

Registered No. G16758

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3701 Mary Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3701 Mary Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Noll

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Katherine Noll
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 10 | 19 | hr. min. |

9. Birthplace Austria
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Peter Noll
13. Birthplace Austria

MOTHER
14. Maiden Name Marie Shaus
15. Birthplace Austria

16 (a) Informant Mrs. Katherine Noll
(b) Address 3701 Maryl Avenue

17 (a) Burial (b) Date thereof 12/24/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date received by registrar) DEC 28 1946 (b) Registrar's signature

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21st 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/23/46 19 to 12/21/1946.
and that I last saw him alive on 12/20/46

Immediate cause of death: Carcinoma of stomach with general metastases — Duration: 1 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation July 1946
Major findings of operation: Exploratory operation inoperable
of autopsy: carcinoma.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Deiter M. D.
Address 1226 Hanover St. Date signed 12/23/1946

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

TN. 87900 G46759 — 92D — Registered No. G46759

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 7- 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2911 Berwick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Edward Bernasco

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widower |

6 (b) Name of husband or wife Mary K.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8th 1864

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | 10 | 13 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation unemployed.
11. Industry or business

FATHER
12. Name Charles Bernasco
13. Birthplace France

MOTHER
14. Maiden Name Amelia Feistel
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records

17 (a) Burial (b) Date thereof 12/26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore
18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road
19 (a) (Date rec'd by registrar) (b) Registrar

VS 150
DEC 23 1946

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH December 21st 1946 at 12.09 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 12th 1944 to Dec. 21st 1946 and that I last saw him alive on Dec 21st 1946

Immediate cause of death Bronchopneumonia — Duration

Due to Arteriosclerotic C-V Disease.

Due to

Other Conditions Diverticulosis, Multiple.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert A. Farbe M. D.
Address Balto. City Hosps Date signed 12-21-46

X

G46760

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 927

G46760 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto.

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 Markley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** SOMMER, ELSIE B.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | W |

6 (b) Name of husband or wife Charles Lekay
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17-1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 2 | 6 | hr. min. |

9. Birthplace Parkton - Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Robert Leese
13. Birthplace Md.

MOTHER
14. Maiden Name Alice Rook
15. Birthplace Md.

16 (a) Informant Mrs. Myra Kennedy
(b) Address 2908 Markley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 | 26 | 46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director L. J. Cook
(b) Address 5305 Harford Rd

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23, 1946 at 9:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 22 1946 to Dec 23 1946 and that I last saw him alive on Dec 23 1946

| Immediate cause of death | Duration |
|---|---|
| Cerebral hemorrhage | |
| accident | |
| Due to HYPERTENSIVE - ARTERIO - SCLEROTIC CARDIO VASCULAR DISEASE | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Gulbrandsen
Address 3706 Rondale Rd. Date signed 12/23/46

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

G16761

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G16761 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 900 N. Bradford St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 N. Bradford St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Labaj

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| X | X |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Veronica Labaj
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1858

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 88 | 11 5 | 15 | hr. min. |

9. Birthplace Austria-Hungary (Town, county, and state)
10. Usual Occupation Wire Worker
11. Industry or business Self- Floral Frames

FATHER
12. Name Paul Labaj
13. Birthplace Austria-Hungary

MOTHER
14. Maiden Name Not Known
15. Birthplace Austria-Hungary

16 (a) Informant A. Edwin Labaj
(b) Address 104 Maryland Ave, Towson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Frank Cvach & Son
(b) Address 900 N. Chester Street

19 (a) (Date rec'd by Registrar) (b) Registrar

DEC 23 1946

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 21 1946, at 2P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 11 1946 to Dec 21 1946 and that I last saw h alive on Dec 21 1946.

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | 12/26/46 |
| Due to Chronic Myocarditis | 1942 |
| Due to Hypertension Cystis Nicolas disease | 1942 |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J Bowers M. D.
Address 801 21 Eastern Ave Date signed 12/26/46

VS 108

X

gcf Hampton

BALTIMORE CITY HEALTH DEPARTMENT X V

# CERTIFICATE OF DEATH 131a

Registered No. 63673

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Va. (b) County
(c) City or town Norfolk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 635 Delaware Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ALBERT SIDNEY KARN

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| None | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 29, 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 9 | 24 | hr. min. |

9. Birthplace Norfolk, Va.
(Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name Joseph H. Karn
13. Birthplace Va.

MOTHER
14. Maiden Name Sallie Warren
15. Birthplace Va.

16 (a) Informant Elmhurst Nursing Home
(b) Address 1708 Eutaw Place

17 (a) Removal (b) Date thereof 12/24/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Elmwood Cem.
Location Norfolk, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION** 30

20. DATE OF DEATH Dec. 23, 1946, at 5 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10-46 1946 to 12-21-1946, and that I last saw him alive on 12-21- 1946

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | |
| Due to Adv. atherosclerosis | |
| Due to | |
| Other Conditions Chr. Nephritis | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis D Jacob M. D.
Address 1700 Eutaw Pl Date signed 12-23-46

Correct age is especially important. Physicians, please write plainly.

VS 150

Huntington Williams, M.D.

X

G16763

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

937

G16763

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3722 Winterbourne Rd.
(c) Hospital or institution:

15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3722 Winterbourne Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARIE MAGDALENE SCHUTZ

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| -- | -- |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife John Philip Schutz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1861

| 8. AGE: Years | Months | Days | If less than one day, |
|---|---|---|---|
| 85 | 5 | 3 | hr. min. |

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Johan Franz
13. Birthplace Germany

MOTHER
14. Maiden Name Zufall
15. Birthplace Germany

16 (a) Informant Mrs. Christine Dadmun
(b) Address 3722 Winterbourne Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** December 22 1946, at 11.48 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec 18 1946 to Dec 22 1946 and that I last saw h[illegible] alive on Dec 22 1946.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 4 Days |
| Due to Cerebral Arteriosclerosis | 2 |
| Due to Hypertensive Cardio-Vascular Disease | 5 |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: none

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature John M. Scott M. D.
Address 8 Ledgewood Road Date signed 25 Dec '46

VS 150

Correct age is especially important. Physicians: please write plainly.

G16764 ✓ G16764

Tn. 106988

BALTIMORE CITY HEALTH DEPARTMENT

Registered No.

# CERTIFICATE OF DEATH 131a

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 Ashland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

**3 (a) FULL NAME** Susie Holmes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Col | Div. |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-10-1901

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 45 | 5 | 13 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward Smith
13. Birthplace Va.

MOTHER
14. Maiden Name Rebecca
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location a a County Md
18 (a) Funeral director Mc Colt & Ellwood
(b) Address 1129 Cathedral St.
19 (a) (Done locally by registrar) (b) Huntington Williams M.D.

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH December 20th 1946, at 2.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 20th 1946 to Dec 20th 1946, and that I last saw her alive on Dec. 20th 1946

| Immediate cause of death | Duration |
|---|---|
| Cerebro-Vascular Accident | |
| Due to Hypertensive C-V. Renal Disease | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert R. Fuller M. D.
Address Balto. City Hosps Date signed 12-20-46

28 1946

VS 150

X

G16765

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

V G16765 Registered No. 83a

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2102 Baker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** PAULINE WARNER

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | |

6 (b) Name of husband or wife Clair H.
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) 1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | | | hr. min. |

9. Birthplace N. Y. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Rock
13. Birthplace N. Y.

MOTHER
14. Maiden Name Johanna Cluney
15. Birthplace N. Y.

16 (a) Informant Daniel Rock
(b) Address Youngstown Ohio

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Kelly Rome
(b) Address 1827 W. North Ave
acting for Wilmington, Del.

19 (a) 1946 (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 21, 1946, at 9.15 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 12-23-46

VS 181

G46766 — BALTIMORE CITY HEALTH DEPARTMENT — G46766 Registered No.

# CERTIFICATE OF DEATH

160 a

OC.G-60818

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town 2nd Dist. (If outside city or town limits, write RURAL and give town)
(d) Street No. 208 Md Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Evans

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-23-46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | hr. 5 min. |

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

**FATHER**
12. Name Albert Evans
13. Birthplace Ohio

**MOTHER**
14. Maiden Name Dorthy Ashman
15. Birthplace Baltimore

16 (a) Informant Albert Evans
(b) Address 208 2nd Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director Joseph Sasmakos Sr
(b) Address 602 Wash. Blvd

19 (a) DEC 23 1946 (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/23 1946, at 1240 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/23 19__, to 12/23 1946, and that I last saw h/xx alive on 12/23 1946.

| Immediate cause of death | Duration |
|---|---|
| Intracranial hemorrhage | |
| Due to Prolonged dystocia | |
| Due to Posterior position & cephalopelvic | |
| Other Conditions Disproportion | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stuart D Rizika M. D.
Address St. Agnes Hosp Date signed 12/23/46

VS 150

correct age is especially important. Physicians: please

G16767

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 181

Registered No. G46767

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore City. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5256 Park Heights Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine E. Slate

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife George A. Slate
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1850

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 96 | 4 | 12 | hr. min. |

9. Birthplace Emmittsburg, Md. (Town, county, and state)
10. Usual Occupation Housewife,
11. Industry or business at home

FATHER
12. Name Joseph Kreitz,
13. Birthplace Germany.

MOTHER
14. Maiden Name Maria Lauer,
15. Birthplace Germany.

16 (a) Informant Miss Slate
(b) Address 5256 Park Heights

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/46 (month) (day) (year)
(c) Cemetery or crematory Mt. St. Mary's Cem.
Location Emmittsburg, Md.

18 (a) Funeral director Lo. Vernon Lesmeister.
(b) Address 4611 Park Heights Ave.

19 (a) (Not to be filled in by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/21/46 19 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-24 19 46 to 12-21 19 46 and that I last saw her alive on 12-21 19 46.

| Immediate cause of death | Duration |
|---|---|
| Cardiorenal failure | |
| Due to degeneration | |
| Due to | |
| Other Conditions 2nd degree burns of back. (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 11-24-46 at 8 P. M
(c) Where did injury occur? 5256 Park Heights Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Flame from gas stove ignited clothing

23. Signature for C. J. Zuromski, by Homer Lesmeister, M.D.
Address West Baltimore Gen. Hosp. Date signed 12/24/46

VS 150

For C. J. Zuromski, by Homer Lesmeister, M.D.

Write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

768

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. C16778

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 821 N. Curley St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 821 N. Curley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick F. Myers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Margaret Myers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19-1878

8. AGE: Years 68 | Months 5 | Days 14 11 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business

FATHER
12. Name Martin Myers
13. Birthplace Germy

MOTHER
14. Maiden Name Rose Eccelson ?
15. Birthplace Md.

16 (a) Informant Frank T Myers
(b) Address 4211 Sumner Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 24/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave.

18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

DEC 27 1946

VS 180

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-21-46 19 at 7:50 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1-45 19 to 12-21-46 19, and that I last saw h/im alive on 12-21-46 19.

Immediate cause of death Terminal Lobular pneumonia — Duration 2-3 Jr

Due to Pulmonary edema + CPC — Duration

Due to Arteriosclerotic Heart disease - Chronic myo-carditis — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. D. Berg
Address 642 North Bl[illegible] Date signed 12-27-46

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

X

Dr. Alex Gage
709 N. Bradway

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

Registered No. 6[illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 611 Radnor Avenue
(c) Hospital or institution: 27-10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 611 Radnor Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Senft

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1861

8. AGE: Years 85 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name John Senft
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Grebner
15. Birthplace Germany

16 (a) Informant Mrs. Elizabeth Kimmett
(b) Address 611 Radnor Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) DEC 24 1946 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/16 1946, to 12/22 1946 and that I last saw h alive on 19

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alex A. Gage, M.D.
Address 709 N Broadway Date signed 12/24/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

C46770
JL - 106501

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1-3 B

Register No. C46770

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 120 S. Ann St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Guy Riddle

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Div. ? |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 6 | 13 | hr. min. |

9. Birthplace Ky
(Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Hercules Maintenance Co.,

FATHER
12. Name George Riddle
13. Birthplace Ky

MOTHER
14. Maiden Name Arebell Moore
15. Birthplace Ky.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12 27 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Cobb
Location Whitehall Ky

18 (a) Funeral director Odell Funeral Home Inc
(b) Address 403 - E - 25th St

19 (a) DEC 24 1946 (b) at Huntington Williamsburg, Md.
(Order rec'd by Registrar)

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec. 22, 1946 at 11.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29 1946, to Dec. 22 1946, and that I last saw h alive on Dec. 22 1946.

| Immediate cause of death | Duration |
|---|---|
| Uraemia | |
| | |
| Due to | |
| | |
| Due to | |
| | |
| Other Conditions Pulmonary tubercu- losis, moderately advanced | 1 year |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. L. Bird M. D.
Address Balto City Hosps Date signed 12-23-46

VS 150

G46771

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

97

Registration No. G36771

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3521 Virginia ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-13
(e) Length of stay in Baltimore (yrs., mos., or days) 41yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3521 Virginia Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Goren

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-10-1878

8. AGE: Years 68 | Months 10 | Days 13 | If less than one day hr. min.

9. Birthplace Russia (Town, county, or state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Schmear
13. Birthplace Russia

MOTHER
14. Maiden Name Munue
15. Birthplace Russia

16 (a) Informant Morris Goren
(b) Address 3521 Virginia ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel Cem
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1454 E Balto St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-23-1946, at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to Dec. 23-46 and that I last saw him alive on Dec. 23-46

Immediate cause of death | Duration
Myocardial failure | 1 hr
Due to Bronchial Asthma | 2 yr
Due to Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Bayless
Address 7040 Eulalia Date signed 12/27/46

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

G46772

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1640

G46772

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Fosterstown Road
(c) Hospital or institution: Seton Institute 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 Moreland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HYMAN ENTEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 52 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Frank
13. Birthplace Russia

MOTHER
14. Maiden Name Peare
15. Birthplace Russia

16 (a) Informant Albert Enten
(b) Address 1607 Morland ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1629 E Balto St

19 (a) (Date rec'd by registrar) (b) for Williams, M.D. Registrar

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/23/46 19 , at 4:20 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Strangulation

Due to Belt around neck (Self-Inflicted)

Other Conditions Ind° Burns face

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/23 at 3:50 A.M.
(b) Where did injury occur? Seton Institute
(c) Did injury occur at home, on farm, industrial place, in public place? Hospital While at work? NO
(d) Means of injury Self Inflicted

23. Signature John R Waters M.D. Medical Examiner.
Date signed 12/23/46

X

G46773

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

97

Registered No. G46773

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 Roslyn Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 - 3

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2228 Eutaw Pl
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Fisher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 79 | Months 8 | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Emanuel Fisher
13. Birthplace Germany

MOTHER
14. Maiden Name unknown
15. Birthplace Germany

16 (a) Informant Martin Dorbrean
(b) Address 2228 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-25-46 (month) (day) (year)

(c) Cemetery or crematory
Location Hebrew Friendship Cem

18 (a) Funeral director Jack Lewis Inc
(b) Address 429 E Balto St

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams M.D.

DEC 24 19

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-23- 1946 at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 1924 to 12/23 1946 and that I last saw h[illegible] alive on 12/2-3 1946

Immediate cause of death: Cerebral Arterio Sclerosis — Duration 5 yrs

Due to: Cerebral Arterio-Sclerosis — 10 yrs

Due to: Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Emma F. Mayer

Address 1 Cathedral Date signed 12/23/46

Erwin E. Mayer

correct age is especially important. Physicians: please write

G46774

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

61

Registered No. G46774

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1525
(c) Hospital or institution: Union Memorial Hospital DHH
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town, write district, and city or town)
(d) Street No. 3506 Leighton Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Henry Glaser

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Fannie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 59 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Riga (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name Nathan
13. Birthplace Riga

MOTHER 14. Maiden Name Sarah
15. Birthplace Riga

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/46 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto Md.

18 (a) Funeral director Jas. Lewis Inc
(b) Address 1439 E. Baltimore St.

19 (a) DEC 24 1946 (Date rec'd by registrar) (b) Huntington Williams Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 23, 1946, at 8:35 P M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G. Kelpius M.D. Medical Examiner.
Date signed Dec 23, '46

VS 151

940

G16775

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 52c

G16775 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2916 Huntingdon
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2916 Huntingdon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Grace Miller

3 (b) If veteran, name war: none | 3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph E. Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 5 1879

8. AGE: Years 67 | Months 1 | Days 17 | If less than one day hr. min.

9. Birthplace Delta Ga (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Wilborn J Pennington
13. Birthplace Ga

MOTHER 14. Maiden Name Margaret Eubanks
15. Birthplace Lonesville Ga

16 (a) Informant Joseph Miller
(b) Address 2916 Huntingdon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/46 (month) (day) (year)
(c) Cemetery or crematory Baptist
Location Ferry Road

18 (a) Funeral director Wilborn C. Fox
(b) Address 1217 E Oliver St

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 1946, at 10:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1946 to 12/22/1946 and that I last saw h[illegible] alive on 12/22/1946

| Immediate cause of death | Duration |
|---|---|
| Respiratory Failure | 1 day |
| Due to Carcinoma of Urethra | 1 yr. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Weaver M.D.
Address 1927 E North Ave Date signed 12/23/46

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G16776

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 178a

Registered No. G16776

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins 2-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1730 Thames St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** OLOF KARLSEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | married |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | | | hr. min. |

9. Birthplace Norway - Oslo
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Norwegian Consul
(b) Address Baltimore Md

17 (a) Cremation (b) Date thereof 12/26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore Md

18 (a) Funeral director Wilson Col Inc
(b) Address 1217 E Fort Ave

19 (a) DEC 24 1946 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/20/46 19 , at 8:25 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ (Probably H.F.M.), suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/20/46 at Found at 7:30 A.M.
(b) Where did injury occur? 1730 Thames st
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Burner of stove turned on + unlit

23. Signature John C. Weis M.D.
Medical Examiner.
Date signed 12/20/46

VS 151

G46777

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93E

G46777 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 211 Garrison Blvd
(c) Hospital or institution: (Beauty Parlor)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3308 Elgin Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Clara L. Waidner

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | no |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | single |

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/16/1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 1 | 7 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired School Teacher
11. Industry or business Balto. City

FATHER
12. Name Louis A. Waidner
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Anna M. Gruetter
15. Birthplace Balto., Md.

16 (a) Informant Harry W. Allers, Nephew
(b) Address 509 Title Bldg.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md. Huntington Williams Mgr

19 (a) DEC 24 1946 (Date filed by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 23, 1946, at 10:15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestive Cardiac failure.

Due to

Other Conditions acute pulmonary Edema

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Malden M.D.
Medical Examiner.
Date signed 12-23-46

VS 151

G46778

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

50 ✓

Registry G46778

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1700 Park Avenue
(c) Hospital or institution:
Wheeler Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-20
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3306 Menlo Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** LILLIAN (LILLIE G. POSKE

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | No |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 1 | 29 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation –
11. Industry or business –

FATHER
12. Name Henry F. Poske
13. Birthplace Md.

MOTHER
14. Maiden Name Emma A. ?
15 Birthplace ? Md.

16 (a) Informant Mrs. Milton C. Poske
(b) Address 14 Overbrook Rd. 28, Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 21, 1946, at 4:40PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/13 1945 to 12/21 1946, and that I last saw her alive on Dec. 21 1945

Immediate cause of death Carcinoma metastasis in lungs & 3rd lumbar vertibrae. — Duration ?
Due to Was operated on for carcinoma of left breast — 2/1/36
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hallett S. Dubbert M. D.
Address 220 Harrison Blvd. Date signed 12/23/46

V S 150

DEC 24 1946

Huntington Williams, M.D.

X

G46779

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

Registered No. G46779

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1420 Ramsay St.
(c) Hospital or institution: 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1420 Ramsay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anna Estella Stiner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Samuel S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1870

8. AGE: Years 76 | Months 5 | Days 3 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robt. Harrington
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Ann Logue
15. Birthplace N. Y.

16 (a) Informant Emma G. Stiner
(b) Address 1420 Ramsay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/46 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Harney, Md.

18 (a) Funeral director Harry H. Wiltse
(b) Address 4101 Edmondson Ave.

19 (a) DEC 24 1946 (Date received by Registrar) Registrar

VS 150

Huntington Williams, M.D.

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 12/22/46; 19..., at 12 noon M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Aug. 15, 1944, to Dec. 22, 1946, and that I last saw h[er] alive on Dec 21, 1946

| Immediate cause of death | Duration |
|---|---|
| Coronary Sclerosis and Congestive heart failure | 3 weeks |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23. Signature** Leonard Gaspe, M.D.
M. D.
Address 310 W. Baltimore St Date signed 12/23/46

X

G46780

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 927

Registered No. G46780

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 950 W. Franklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 d
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 950 W. Franklin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Samuel Palmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Col. | Married |

6 (b) Name of husband or wife Clara Palmer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9, 1897

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 49 | 9 | - | hr. min. |

9. Birthplace Centerville Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Samuel Palmer

13. Birthplace Md.

MOTHER 14. Maiden Name Mary Dwright

15. Birthplace Md.

16 (a) Informant Clara Palmer

(b) Address 950 W. Franklin St.

17 (a) Burial (b) Date thereof Dec. 24/946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N. Schroeder St. Huntingtown Williams

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19- 1946, at 7.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-13- 1946 to 12-19- 1946, and that I last saw h. alive on 12-19- 1946

Immediate cause of death Valvulitis — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address 611 N. Carey St. Date signed 12-23-46

V S 150

DEC 24 1946

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

Registered No. 646781

646781

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1706 W Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-3
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give name)
(d) Street No. 1706 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William R. Small

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Col.

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Grace Small

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1892

8. AGE: Years 54 Months - Days - If less than one day hr. min.

9. Birthplace Chesterfield Va.
(Town or county and state)

10. Usual Occupation Boiler Mach

11. Industry or business

FATHER
12. Name John H. Small
13. Birthplace Fairmount Md.

MOTHER
14. Maiden Name Milley Henry
15. Birthplace Fairmount Md.

16 (a) Informant Grace Small
(b) Address 1706 W. Lanvale St

17 (a) Burial (b) Date thereof Dec. 24 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 1946, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 18 1946, to Dec 21 1946, and that I last saw h. alive on Dec 20 1946

| Immediate cause of death | Duration |
|---|---|
| Coronary Occlusion | 4 days |
| Due to | |
| Due to | |
| Other Conditions Hypertensive | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Douglas Sheppard M. D.
Address 604 N. Bullitt ave Date signed 12/23/46

V S 15 DEC 24 1946 Huntington Hollins

X

G46782

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 548

G46782 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 201
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 524 Edgewood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Samuel Ellmore

3 (b) If veteran, name war —
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6. (b) Name of husband or wife Emma Meade
6 (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) Dec 27, 1912

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 33 | 11 | 26 | hr. min. |

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Section Dept
11. Industry or business Dept Store

FATHER
12. Name Samuel Ellmore
13. Birthplace Va

MOTHER
14. Maiden Name Lulu May Farnham
15. Birthplace Va

16 (a) Informant Mrs. Emma Ellmore
(b) Address 524 Edgewood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/46 (month) (day) (year)
(c) Cemetery or crematory Ketoctin Cem.
Location Purcellville, Va

18 (a) Funeral director John F Heinz Inc
(b) Address 710 Light St

19 (a) DEC 24 1946 (Date received by Registrar) (b) Clayton Williams M.D. Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec 22 19 46, at 4 pm M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 11/20 19 46 to 12/22 19 46 and that I last saw h alive on 12/22 19 46.

| Immediate cause of death | Duration |
|---|---|
| Carbon Fracture | |
| Due to Injury right ankle comp. & Post. dislocation astragal valve | |
| Due to Coronary Sclerosis Endocarditis | |
| Other Conditions Rheumatic Heart Disease | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Irving Porter
Address Sinai Hosp Date signed 12/22/46 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G46783

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

G46783
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 305 Pontiac Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-4
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 305 Pontiac Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Mary E. Longest

3 (b) If veteran, name war —
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Nathan
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Feb 15th 1858

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 88 | 10 | 8 | ____ hr. ____ min. |

9. Birthplace A. A. Co. Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Thomas Dyson
13. Birthplace Maryland

MOTHER
14. Maiden Name Susan Boyer
15. Birthplace Maryland

16 (a) Informant Mrs. Grace Schnepfe
(b) Address 305 Pontiac Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/46 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd.

18 (a) Funeral director John F. Henry Inc
(b) Address 745 Light St.

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 22nd 1946 at 9:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to Dec 23 1946 and that I last saw h[illegible] alive on Dec 23 1946.

| Immediate cause of death | Duration |
|---|---|
| Coronary occlusion | |
| Hypertensive cardio | |
| vascular disease. | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. J. Kirsten, MD
Address 202 Patapsco Ave. Date signed 12/27/46

VS 150

Hunting for Mildred

6

X

G46784

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93E

Registered No. G46784

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 516 S. Wolfe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 S. Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Berdych

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | M. |

6 (b) Name of husband or wife Michael
6 (c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) Not Known

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| About 65 | | | hr. min. |

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Zarzycki
13. Birthplace Poland

MOTHER 14. Maiden Name
15. Birthplace Poland

16 (a) Informant Wlodzimir Berdych
(b) Address 516 S. Wolfe

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wenk & Fialkowski
(b) Address 2007 Eastern Ave

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 21 1946, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1946 to Dec. 21 1946 and that I last saw h[illegible] alive on Dec. 21 1946

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Edema | 1 day |
| Due to Chronic Myocardial Insufficiency | 1 yr |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ethel V. Zajdowicz M. D.
Address 1902 Eastern Ave Date signed 12-27-46

correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS 150

DEC 24 1946

G46785

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 47c

Registered No. G46785

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 St. Paul St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward J. Reilly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. ~~Single~~ ~~Married~~ ~~Widowed~~

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 59 Months Days If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Motion Picture Operator

11. Industry or business

FATHER 12. Name John T. Reilly
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Mary Agnes Mee
15. Birthplace Baltimore Md

16 (a) Informant Miss Rose Reilly
(b) Address 1626 St Paul St

17 (a) Cremation (Burial), cremation, or removal (b) Date thereof 12-26-1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Wiedefeld & Son
(b) Address 201 E. 22nd St

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 24 1946

VS 100

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/22 1946, at 2:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/9 1946 to 12/22 1946 and that I last saw him alive on 12/21 1946

Immediate cause of death Pulmonary Hemorrhage — Duration

Due to Bronchogenic Carcinoma

Due to

Other Conditions Bronchopleural fistula

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D. Wells M. D.
Address 16 W. Mt. Vernon Pl. Date signed 12-22-46

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G46786

505725

BALTIMORE CITY HEALTH DEPARTMENT X

# CERTIFICATE OF DEATH 75c

G46786
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Queen Annes
(c) City or town Rt # 2 Centreville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anna Elizabeth Kennedy.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Black | |

6 (b) Name of husband or wife William.
6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) 11-21-19.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 27 | 1 | 2 | hr. min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Home-wife
11. Industry or business

FATHER
12. Name Amos Hyman
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah E Jones.
15. Birthplace Md

16 (a) Informant Reads
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 12-27-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Burrisville
Location Burrisville, Md.
18 (a) Funeral director C. K. Lane
(b) Address Church Hill, Md
19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION** P.

20. DATE OF DEATH Dec - 23 1946, at 7.15 M
21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 3 1946 to Dec - 23 1946, and that I last saw her alive on Dec - 23 1946.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | |
| Due to Thrombocytopenia purpura idiopathic | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 12-20-46
Major findings of operation: Splenectomy
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward L Dyson
Address Johns Hopkins Hospital Date signed 12-24-46 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G46787

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 937

G46787 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins ave at Caton
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto. Halethorpe
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1244 Frances ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances P. Adams.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. ✓

6 (b) Name of husband or wife Edward Adams.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 15 1901

8. AGE: Years 45 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation House Wife.

11. Industry or business

FATHER
12. Name Makowski (deceased)
13. Birthplace Europe

MOTHER
14. Maiden Name
15. Birthplace Europe

16 (a) Informant Edward Adams
(b) Address 1244 Frances ave Halethorpe

17 (a) Burial (b) Date thereof 12-22-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem
Location Balto. County

18 (a) Funeral director John Mc Weber
(b) Address 404 S. Chester Street

19 (a) 12 23 1946 (b) Penitentiary Warden
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 1946, at 8.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death Cardiac failure Duration
Cerebral vascular accident

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed 12/23

Please write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write the

VS 150

946788

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. 946788

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 11th
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 445 - Cummings Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Russell H. HAYES

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| male | Colored | |

6 (b) Name of husband or wife Teona

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1912

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 34 | 9 | 19 | hr. min. |

9. Birthplace Roanoke, Va
(Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name John Hayes
13. Birthplace Roanoke, Va

MOTHER
14. Maiden Name Lula Franna
15. Birthplace Roanoke, Va

16 (a) Informant Teona Hayes
(b) Address 445 Cummings Ct.

17 (a) Burial (b) Date thereof 12-24-1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Mountain Hill, Va

18 (a) Funeral director Jas. H. Holland
(b) Address 1631 Druid Hill Ave.

DEC 24 1946 (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Dec. 21 1946, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 12/27/46

VS 151

6789

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1210

C46789 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2105 Hargrove Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2105 Hargrove Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Emma L. Kemp.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1882

8. AGE: Years 64 | Months 2 | Days 12 | If less than one day hr. min.

9. Birthplace Gloucester Co. Va (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Joseph Kemp
(b) Address Ordinary P.O. Gloucester Co. Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-1946 (month) (day) (year)
(c) Cemetery or crematory Abberton Cem
Location Gloucester Co. Va

18 (a) Funeral director Mrs. Lena H. Holland
(b) Address 1631 David Hill Ave

DEC 24 1946 (c) Registrar's signature Huntington Williams M.D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 1946, at 4:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1946, to Dec 22 1946, and that I last saw h[illegible] alive on Dec 4 1946

Immediate cause of death: Cardiac Renal Disease — Duration: 3 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hunt A Williams M.D.
Address 2329 Guilford Ave Date signed Dec 22 1946

6790 28974

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH / 463

G46790 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1916 McCulloh St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abdul Kareem

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Black | Married |

6 (b) Name of husband or wife Kareema
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-26-06

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 40 | 9 | 25 | hr. min. |

9. Birthplace Ga. (Town, county, and state)
10. Usual Occupation Dairy worker
11. Industry or business

FATHER
12. Name Abdul Kareem
13. Birthplace Egypt

MOTHER
14. Maiden Name Rahieem Salah
15. Birthplace Egypt

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-1946 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem. Park
Location Baltimore Co. Md.
18 (a) Funeral director Mrs. George A. Holland
(b) Address 1631 Druid Hill Ave
19 (a) DEC 24 1946 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION 30

20. DATE OF DEATH Dec 21 1946 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11 1946 to Dec 21 1946 and that I last saw him alive on Dec 21 1946

Immediate cause of death Carcinoma of the stomach with the metastasis to regional nodes, peritoneum, liver — Duration 6 mos

Due to

Due to

Other Conditions Acute Rheumatic Pneumonia. Obstructive Jaundice (Include pregnancy within 3 months of death) — 1 yr.

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene Meyer III M.D.
Address Johns Hopkins Hosp. Date signed Dec 24 46

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46791

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1939

G46791 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1609 N. Gilmor st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 N. Gilmor St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Rosie Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1893

8. AGE: Years 53 | Months 5 | Days 3 | If less than one day hr. min.

9. Birthplace Mayo Co. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Richard Garrison
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Mears
15. Birthplace md.

16 (a) Informant Edward Hall
(b) Address 1609 N. Gilmore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/39 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Chas. O. Wilson
(b) Address 1000 Brantly Ave

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20, 1939, at 2:15 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy & Inq thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions Acute Pulmonary Edema.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard A. Mueller M.D. Medical Examiner.
Date signed 12-20-39

DEC 21 1939

Registrar

VS 151

Lillian L. Pott

G46792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 111B

G46792 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5-
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Don.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 Low St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Lottie Pott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years 43 | Months | Days | If less than one day hr. min.

9. Birthplace Turners Station Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Hanley
13. Birthplace Turners Station Md

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Williams Potts
(b) Address 1106 Low St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Elroy A Wilson

18 (a) Funeral director
(b) Address 1000 Brantley Ave

19 (a) DEC 24 1946 (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 21 1946, at 4:00 P. M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Acute pulmonary Edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Williams T Pottes M.D. Medical Examiner

Date signed 21 Dec 46

VS 151

G46793

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1860

G46793
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2025 W Fayette St.
(c) Hospital or institution: Bon Secours Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ Dy
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md., (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 N. Paca St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Joseph Shukis

3 (b) If veteran, name war

3 (c) Social Security Account No. 647-12-364

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1925

8. AGE: Years 21 | Months | Days | If less than one day hr. min.

9. Birthplace Waterbury Conn
(town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Stanley Shukis
13. Birthplace Lith

MOTHER
14. Maiden Name Adina Baker
15. Birthplace Upper Cty

16 (a) Informant Stanley Shukis
(b) Address 135 Congress ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-46 (month) (day) (year)

(c) Cemetery or crematory St Joseph's Cem Waterbury Conn
Location

18 (a) Funeral director Joseph Kaminskas
(b) Address 60 Bridge St. Waterbury Conn

19 (a) (b)
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23 1946, at 7:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 22 1946 to Dec. 23 1946, and that I last saw him alive on Dec. 23 1946.

| | Duration |
|---|---|
| Immediate cause of death: Respiratory failure | |
| Due to: Epidural Haemorrhage as result of fractured skull | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation Dec. 22, 1946
Major findings of operation: Epidural Haemorrhage; Rt. temporal region & autopsy: fractured skull

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 17/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Dec 22, 1946 at 3:00 P.M.
(c) Where did injury occur? Baltimore Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public While at work? Student
(Specify type of place)
(e) Means of injury Fell about 20 feet

23. Signature Joseph R Pilecki M. D.
Address Bon Secours Hosp Date signed 12/23/46

For P. C. J. Lubinski, by Howard L. Weiss, M.D.

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G46794

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46E

G46794 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2225 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SHIRLEY FELDMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years 42 | Months | Days | If less than one day hr. min.

9. Birthplace Newport News Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Jacob
13. Birthplace Russia

MOTHER 14. Maiden Name Ida
15. Birthplace Russia

16 (a) Informant Louis Feldman
(b) Address 2225 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-25-46 (month) (day) (year)
(c) Cemetery or crematory
Location Newport News Va

18 (a) Funeral director Jack Lewis Inc
(b) Address 419 E Dale St

19 (a) (Date received by local registrar) (b) Signature for Hillman H. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-24 1946, at 4:17 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-7 1946 to 12-24 1946, and that I last saw h alive on 12-24 1946.

| | Duration |
|---|---|
| Immediate cause of death: Peritonitis | |
| Due to: Ca of sigmoid | |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Sinai Hosp Date signed 12-24-46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G46795 Bel 7th

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1140C

G46795 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital 13

(d) Length of stay in hospital or inst. (yrs., mos., or days) 96
(e) Length of stay in Baltimore (yrs., mos., or days) 36

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE, 11 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 PAINE ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MAXINE ODIOUS HOWARD

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| FEMALE | WHITE | MARRIED |

6 (b) Name of husband or wife MR. LONNIE HOWARD
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 21, 1911

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 35 36 | 0 | 2 | hr. min. |

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business

FATHER
12. Name ? RIDENORE
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MARGARET SENCE
15. Birthplace MARYLAND

16 (a) Informant HOSPITAL RECORD
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 26-4 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore

18 (a) Funeral director Frank H. Seitz
(b) Address 814 N. 36 St.

19 (a) (Date received by registrar) (b) Registrar

DEC 23 1946 Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 23, 1946 at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT. 16, 1946 to DEC. 23, 1946 and that I last saw HER alive on DEC. 23, 1946

Immediate cause of death Subacute bacterial endocarditis — Duration 85 days

Due to Rheumatic heart disease — ?

Due to

Other Conditions Septic abortion — 5 mos.

(Include pregnancy within 3 months of death)

Date of operation SEPT. 27, 1946

Major findings of operation: SEPSIS OF REMOVAL of RUDIMENTARY APPENDIX

(If autopsy was performed, state whether findings of autopsy confirm diagnosis. The question of [illegible] should be answered in all cases.)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter C. Merkel, M.D.
Address Union Memorial Hosp. Date signed 28 Dec '46

Howard J. Merrill, M.D.

## PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46796 92B

Registered No. G46796

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1410 N. Eden st
(c) Hospital or institution: 9-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 N. Eden st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Wells Jenkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Joseph Jenkins

6 (c) If alive, age years

7. Birth date of deceased (mo., day, yr.) May-22-1876

8. AGE: Years 70 | Months 6 | Days 219 | If less than one day hr. min.

9. Birthplace Long Green Balto County Md.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Myrtle Kerr
(b) Address 328 N. Strieker st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-46 (month) (day) (year)
(c) Cemetery or crematory Long Green
Location Harford County Md

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 E. Jefferson st.

19 (a) Filed 1946 (b) Registered by registrar Lington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December-21 1946, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1946 to Dec 21 1946, and that I last saw h[illegible] alive on Dec 20 1946

Immediate cause of death: Cerebral Hemorrhage

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Edward Fisher

Address 1612 E. Monument Date Dec 23 1946

Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

VS 150

6797

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 108

Registered No. C46797

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 835 EDMONSON AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 835 EDMONSON AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wm. Love

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| MALE | COLORED | MARRIED |

6 (b) Name of husband or wife ALMA
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3-15-1908

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 38 | 9 | 9 | ____ hr. ____ min. |

9. Birthplace VIRGINIA
(Town, county, and state)
10. Usual Occupation PORTER
11. Industry or business B. & O. R.R.

FATHER
12. Name HENRY LOVE.
13. Birthplace Va.

MOTHER
14. Maiden Name ELVA ROBINSON
15. Birthplace Va.

16 (a) Informant ALMA LOVE
(b) Address 835 EDMONSON AVE.

17 (a) Burial (b) Date thereof 12-27-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ARBUTUS MEM-PARK.
Location BALTIMORE COUNTY - Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania ave.

19 (a) 1-7-1947 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1946, at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-02 1946 to 12-24 1946 and that I last saw h[illegible] alive on 12-24 1946.

| Immediate cause of death | Duration |
|---|---|
| Lobar Pneumonia | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 1134 Harlem Ave Date signed 12/29/46

copies age is especially important. Physicians: please write

G46798

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 94a

Registered No. G46798

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 260 Court a -Oaklee Villa ge
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John H. Anderson

3 (b) If veteran, name war: no

3 (c) Social Security Account No. no

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife: Ruth V. Anderson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 12, 1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | 9 | 11 | hr. min. |

9. Birthplace: Winchester, Va. (Town, county, and state)
10. Usual Occupation: Police Sgt.
11. Industry or business: Radio Division Central Police Hdqrs.

FATHER
12. Name: Robert L. Anderson
13. Birthplace: Winchester, Va.

MOTHER
14. Maiden Name: Nellie Nicewarner
15. Birthplace: Va.

16 (a) Informant: Mrs. Ruth V. Anderson
(b) Address: Oaklee Villa ge

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) DEC 24 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23, 1946, at 12 P 96 M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullis M.D.
Medical Examiner.
Date signed 12-23-46

X

G46799

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G46799

Please write the cause of death clearly and legibly. Physician's please

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1811 Park Ave.
(c) Hospital or institution:
none 13 2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 Park Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Helen M. Coale

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 7 | -- | hr. min. |

9. Birthplace Cecil County, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Lewis H. Coale
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Matthews
15. Birthplace Md.

16 (a) Informant Margaret N. Coale
(b) Address 1811 Park Ave.

17 (a) Burial (b) Date thereof 12/26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 24 December 1946, at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 24 December 1946 to 24 December 1946, and that I last saw h[illegible] alive on 24 Dec. 1946

| Immediate cause of death | Duration |
|---|---|
| acute pulmonary edema | 4 hours |
| Due to acute myocarditis | 12 hours |
| Due to arteriosclerosis | several years |
| Other Conditions none | |

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Randall Smith, Jr. M. D.
Address 1014 St. Paul St. Date signed 24 Dec 46

Howard J. Andersen, M.D. X

G46800

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 50

Registered No. G46800

1. PLACE OF DEATH: ST Josophis Hosp
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST Josephis Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTIMORE
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 305 WOODBOURNE AVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Alice A. Mc CAHAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife JOHN C. McCAHAN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/6/89

8. AGE: Years 57 | Months 10 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace VIRGINIA (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Eugene R. Mason
13. Birthplace Va

MOTHER
14. Maiden Name Ida Boyd
15. Birthplace Va

16 (a) Informant J. C. McCahan
(b) Address 305 Woodbourne Ave

17 (a) Burial (b) Date thereof 12 27 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Md.

18 (a) Funeral director Lazenby Funeral Home
(b) Address 7401 Belair Rd.

19 (a) 26 (b) Transcription from William M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 24 Dec 1946, at 10 25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/23 1946 to 12/24 1946, and that I last saw h alive on 24 Dec 1946

| | Duration |
|---|---|
| Immediate cause of death: Carcinomatosis | |
| Due to: Carcinoma of breast | |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)

Date of operation 11-5-46

Major findings of operation: Carcinomatosis

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William L. McAuliffe M. D.
Address St Josephs Hosp Date signed 12-27-46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G46801

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1946

G46801 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 206 S. Fagley
(c) Hospital or institution: 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 206 S. Fagley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** John G. Rosengarn

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-07-2632

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Minnie Rosengarn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 11th 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 11 | 12 | hr. min. |

9. Birthplace Balto. Co. Md. (Town, county, and state)
10. Usual Occupation Sanitation
11. Industry or business Bethlehem Steel

FATHER 12. Name John Rosengarn
FATHER 13. Birthplace Balto. Co.

MOTHER 14. Maiden Name Caroline Gegner
MOTHER 15. Birthplace Balto. Co. Md.

16 (a) Informant Mrs. John Rosengarn
(b) Address 206 S. Fagley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 26 46 (month) (day) (year)
(c) Cemetery or crematory Zion Luth.
Location Balto Co Md

18 (a) Funeral director Lazarus Funeral Home
(b) Address 2401 Belair Rd.

19 (a) 25 (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 23rd 1946, at 1 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24 1946 to Dec 23 1946, and that I last saw h[illegible] alive on Dec 20 1946.

Immediate cause of death: coronary occlusion — Duration: 10 min

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edgar L. Gentzler M. D.
Address 3139 E. Baltimore Date signed 12-27

X 451

VS 150

G46802

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G46802 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1926 E Pratt st.
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2"
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore 31
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1926 E Pratt st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Frances Janka

3 (b) If veteran, name war

3 (c) Social Security Account No. none

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | White | Widow |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct-23-1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 2 | 1 | hr. min. |

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Frances Baelawski
(b) Address 1926 E Pratt st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-46 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore Md.

18 (a) Funeral director George A Weber
(b) Address 705 S Pinna st

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24th 1946, at 8 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 1946 to Dec 24 1946 and that I last saw h[er] alive on Dec 24, 1946

| Immediate cause of death | Duration |
|---|---|
| Acute coronary thrombosis | days |
| Due to Coronary Atherosclerosis & Chr. Hypertension | 7 |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature M. D.
Address 700 E Pratt st Date signed 12/29/46

VS 8

Huntington Williams

G46803

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G46803 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 110 S. Catherine St.
(c) Hospital or institution: 20-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 S. Catherine St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

**3 (a) FULL NAME** Anna Theresa Wirtz

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Edward Wirtz
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) August 26, 1882

8. AGE: Years 64 | Months 3 | Days 28 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name James Ferguson
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Esther Hyatt
(b) Address 2716 Westwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-46 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Avenue

DEC 25 1946 (Date rec'd by registrar) Municipal Worker Williamsport, Md.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 23, 1946, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 26 1945 to 12/23 1946, and that I last saw her alive on 12/23 1946.

| | Duration |
|---|---|
| Immediate cause of death: Coronary Occlusion | 10 Hr |
| Due to: Cardio-Vascular Disease | 6 Yrs |
| Due to: | |
| Other Conditions: Diabetes Mellitus | 4 Years |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eliot W. Johnson M. D.
Address 3432 Frederick Ave Date signed

93

C46804

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. C46804

CWK-105175

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eatern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 12-
(e) Length of stay in Baltimore (yrs., mos., or days) 4 to 5 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 S. Chapel Gate Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Minnie Smoot

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~. Married

6 (b) Name of husband Jake M. Smoot

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17-18[illegible]

8. AGE: Years 78 | Months 5 | Days 6 | If less than one day hr. min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Louis Staub
13. Birthplace South Carolina

MOTHER
14. Maiden Name Dora Burkhalter
15. Birthplace South Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/46 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 S. Paul St.

DEC 25 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 1946, at 8:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 11 1946 to Dec. 23 1946 and that I last saw her alive on Dec. 23 1946

Immediate cause of death: Adenocarcinoma of cervix uteri.

Due to

Due to

Other Conditions Cerebral Vascular accident

(Include pregnancy within 3 months of death)

Date of operation 10-21-46

Major findings of operation: Carcinoma of Cervix

of autopsy:

Duration: 12 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marvin M. Long M. D.

Address Baltimore City Hospitals Date signed 12-24-46

VS 150

Please write clearly. Physicians: the entries on death certificates are important. Be sure that the correct age is especially important.

G46805

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G46805

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 404 S Eaton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 404 S Eaton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis H. Jr Korn

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4 Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Kathryn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 22. 1877

8. AGE: Years 69 Months 2 Days 1 If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Cabinet

11. Industry or business Salt Glazed Co

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant John H. Korn
(b) Address 404 S Eaton St

17 (a) Burial (b) Date thereof Dec 26-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery
Location East End of North Ave

18 (a) Funeral director Weisinger Early Inc
(b) Address 817 St Paul Streets

19 (a) DEC 25 1946 (b) Huntington Wills Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1946 at 1:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21 1946 to Dec 23 1946 and that I last saw him alive on Dec 23 1946

| Immediate cause of death | Duration |
|---|---|
| Cerebral hemorrhage | 3 days |
| Due to Arteriosclerosis | 3 yrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury A. LEE HIGHAW

23. Signature A. Lee Highaw M. D.

Address 411 C Northern Parkway Date signed Dec 23/46

correct age is especially important. Physicians: please write the

VS 150

G46806 G46806

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1411 Homestead St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1411 Homestead St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Addie L Mills

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| W | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Black | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14, 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 10 | 9 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John M Mills
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Eva Goodmon
15. Birthplace Baltimore Md

16 (a) Informant Susan Lee
(b) Address 1411 Homestead St

17 (a) Final (b) Date thereof 12/26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Tilhon Colt Inc
(b) Address 1219 E Lanvale St

19 (a) DEC 25 1946 (b) Cantin for Williams, M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1946, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1946 to Dec 23 1946 and that I last saw her alive on Dec 20 1946

| Immediate cause of death | Duration |
|---|---|
| Myocardial Degeneration | 6 mos |
| Due to Arteriosclerosis | 3 yrs. |
| Due to Senility | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. J. Hannigan M. D.
Address 1710 E 33rd Date signed 12/24/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G16807 G16807

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 832a

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5519 Minnimoka Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 5519 Minnimoka Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Ellen Pugh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single, married~~, widowed, or divorced. Widowed

6 (b) Name of husband William Pugh

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13th 1866

8. AGE: Years 80 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business Own Home

FATHER 12. Name Jonathan Wissinger

13. Birthplace Pa.

MOTHER 14. Maiden Name Anna Miller

15. Birthplace Pa.

16 (a) Informant Ida Reed

(b) Address 5519 Minnimoka Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/46 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville Md

18 (a) Funeral director Williams Coal Inc

(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) DEC 23 1946 (b) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 23rd 1946 8:50 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1946, to Dec 23 1946, and that I last saw her alive on Dec 23 1946.

| | Duration |
|---|---|
| Immediate cause of death: Cerebral Accident Vascular | Dec 10 1946 |
| Due to: Arteriosclerosis - generalized | ? |
| Due to: | |
| Other Conditions: Uraemia - terminal (Include pregnancy within 3 months of death) | 2 days |

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wheaton E Lawson M.D.

Address 4643 Park Heights Ave Date signed 12/24/46

VS 150

G46808

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 94a

Registered No. G46808

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General 15-H
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1939 Herbert st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Harry E. Monroe

3 (b) If veteran, name war —
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Julia W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 6 | 17 | hr. min. |

9. Birthplace Ohio.
(Town, county, and state)
10. Usual Occupation Sheet metal worker
11. Industry or business Retired

FATHER
12. Name Harvey Monroe
13. Birthplace Ohio

MOTHER
14. Maiden Name Unknown
15. Birthplace Ohio

16 (a) Informant Mrs. Julia W. Monroe
(b) Address 1939 Herbert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/46 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Joppa, Md.

18 (a) Funeral director John J. Conway & Son
(b) Address 1642 E. Baltimore St.

19 (a) DEC 25 1946 (Date rec'd by registrar) [illegible] Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23rd 1946, at 12 30 P.M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Life death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 12/24/46

VS 151

46809- 106436

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 186a

Registered No. G46809

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1321 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Eugene James Riley

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 4 | 17 | hr. min. |

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Car Builder

11. Industry or business

FATHER
12. Name Michael James Riley
13. Birthplace R. I.

MOTHER
14. Maiden Name Catherine Gilson
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/25/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Road

18 (a) Funeral director John E. Conway & Son
(b) Address 901-23 Baltimore St.

19 (a) DEC 27 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22, 1946, at 7.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 28 1946, to Dec. 22 1946, and that I last saw h im alive on Dec. 22, 1946

Immediate cause of death: Uremia — Duration

Due to Benign Hypertrophia of Prostate, & Ulcerating Obstruction

Due to

Other Conditions: ② Arteriosclerotic Cardio vascular Disease
② Fracture neck of Left femur
(Include pregnancy within 3 months of death)

Date of operation 12-22-46

Major findings of operation: Fracture neck of left femur

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 19-2
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence About October 15 1946 at ? M
(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury: Fell when sitting on bed. - Missed bed, falling on floor

23. Signature M. A. Levy M. D.

Address Baltimore City Hospitals Date signed 12-24-46

VS 150

G46810

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G46810 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 215 Wendover Rd.
(c) Hospital or institution: 12-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 215 Wendover Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. John Staige Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Kathleen Bowdoin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1872

8. AGE: Years 74 | Months 11 | Days 8 | If less than one day hr. min.

9. Birthplace Va. (town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER
12. Name Wm. B. Davis
13. Birthplace Va.

MOTHER
14. Maiden Name Haviland
15. Birthplace Va.

16 (a) Informant Mrs. Kathleen Davis
(b) Address 215 Wendover Rd

17 Cremation (Burial, cremation, or Removal) (b) Date thereof 12/26/46 (month) (day) (year)

(c) Cemetery or crematory Greenmount
Location Greenmount Ave. & Oliver St.

18 (a) Funeral director Harry H. Mitzke
(b) Address 4101 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23/46 19..., at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 13 1946 to Dec 23 1946 and that I last saw h/m alive on Dec 23 1946

| Immediate cause of death | Duration |
|---|---|
| Coronary Occlusion | |
| Cerebral Sclerosis | |
| Due to | |
| | |
| Due to | |
| | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter A. Dreyer M.D.
Address 1101 St Paul St Date signed 12/24/46

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

DEC 26 1946

X

D46811

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 74A

Registered No. D46811

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts. 27-15
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 57
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2414 Rogers Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Emily Jane NEUMAN

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | S |

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 13, 1927

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 19 | 4 | 11 | — hr. — min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation School
11. Industry or business

FATHER
12. Name Isadore Neuman
13. Birthplace Virginia

MOTHER
14. Maiden Name Blanche Haas
15. Birthplace Baltimore, Md.

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/46 (month) (day) (year)
(c) Cemetery Baeth Hebrew
Location Balto. Md.

18 (a) Funeral director Baird Goodheim & Lee
(b) Address 902 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 26 1946

VS 150

Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 24 1946, at 4:09 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 29 1946, to Dec 24 1946, and that I last saw h— alive on Dec 24 1946.

| Immediate cause of death | Duration |
|---|---|
| Acute monocytic leukemia | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Crawford N. Kilpatrick, Jr. M.D.
Address Union Memorial Hosp. Date signed 12/24/46

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G46812

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 61

Registered No. G46812

Type or print plainly in ink. Physicians: please write the causes of death clearly and legibly. Give exact place of death and full name of deceased. If not in a hospital or institution, give residence instead of street address. Fill in all items if possible. Underline the cause to which death should be charged statistically. Sign certificate and return promptly to the Registrar. Please see that the certificate is complete and correct as is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1170 Cleveland St
(c) Hospital or institution: 21-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1164 Cleveland St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Katherine Daniels

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Wm. N. Daniels

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept 23 1879

8. AGE: Years 72 (74) | Months 3 | Days 10 | If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: House Wife

11. Industry or business

FATHER — 12. Name: Andrew Lenhardt

13. Birthplace: Balto Md

MOTHER — 14. Maiden Name: Unknown

15. Birthplace:

16 (a) Informant: Elizabeth Harle

(b) Address: Chadbourn N.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec 27 1946 (month) (day) (year)

(c) Cemetery or crematory: London Park

Location: City

18 (a) Funeral director: Mc Nees, John M. Deufel & Son

(b) Address: 5311 Edmondson Ave

19 (a) (b) Registrar

DEC 28 1946 (Date filed by Registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Dec 24 1946 at 4 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1946 to Dec 24 1946, and that I last saw her alive on Dec 23 1946.

| Immediate cause of death | Duration |
|---|---|
| (a) Coronary Occlusion | 2 hrs |
| Due to Arteriosclerosis | 15 Yrs. |
| Due to | |
| Other Conditions: Diabetes Mellitus & Partial Intestinal Obstruction (Include pregnancy within 3 months of death) | 10 yrs |

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Thos P. Ulrich, Jr M. D.

Address 1220 Wash Date signed Dec 26 1946

94a

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH G46813

Registered No. [redacted] G46813

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial Hospital
D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Va. Md. (b) County.....
(c) City or town Baltimore (Dundalk) (If outside city or town limits, write RURAL and give town)
Found Lyman's Park- Charles & 31st St.
(d) Street No..... (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

**3 (a) FULL NAME** Otis Atkins

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 5 | | hr. min. |

9. Birthplace Danville Va
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Birdie L Atkins
13. Birthplace Va

MOTHER
14. Maiden Name Frances Smead
15. Birthplace Va

16 (a) Informant Mrs. Funeral Home
(b) Address Danville Va

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 12/25/46 (month) (day) (year)
(c) Cemetery or crematory Danville
Location Danville Va

18 (a) Funeral director Tilhom & Son Inc
(b) Address 1217 E Cont St

19 (a) [illegible] (b) [illegible]
(Died in or outside hospital) (Registrar)

VS 151

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec. 23, 1946 at 12 p M

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Alcoholism

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature George L Merrill M.D.
Medical Examiner.
Date signed 12/25/46

G46814

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1312a

Registered G46814

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3102 Remington Ave
(c) Hospital or institution: 12-7

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0

(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3102 Remington (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Dudek

3 (b) If veteran, name war No | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Della Dudek
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17 1888

8. AGE: Years 58 | Months 9 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Painter + Decorator

11. Industry or business Interior Decorating Co

FATHER
12. Name Joseph Dudek
13. Birthplace Austria

MOTHER
14. Maiden Name Barbara Sedlacek
15. Birthplace Austria

16 (a) Informant Della Dudek
(b) Address 3102 Remington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Frank Ovach & Son
(b) Address 900 N. Chester St.,

19 (a) (Date received by registrar) (b) Registrar

DEC 26 1946 Huntington

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 23 1946, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21 1946 to Dec 23 1946 and that I last saw h.e alive on Dec 22 1946

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 2 hrs |
| Due to Arterio Sclerosis | 1 yr |
| Due to Hypertension | 1 yr |
| Due to The Intermediate Nephritis | 1 yr |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I F A Stevens M. D.
Address 2818 Harford Av Date signed 12-24-46

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Statement of age is especially important.

Child Certificate
G46815
V-6644B

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

Registered No. G46815

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave
(c) Hospital or institution: Md. Gen'l Hosp. 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Md. Gen'l Hosp (Newborn)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Walter Lippincott II

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/21/46

8. AGE: Years | Months | Days 3 | If less than one day hr. min.

9. Birthplace Balto. Md. Md. Gen Hosp.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Robt W. Lippincott
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Marcia
15. Birthplace Florida

16 (a) Informant Marcia Lippincott
(b) Address 3507 6th Ave Bridge

17 (a) Burial (b) Date thereof Dec 26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson, Md

18 (a) Funeral director John O. Mitchell Sons Inc
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-24-46 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-21 1946 to 12-24 1946, and that I last saw him alive on 12-24 1946

| Immediate cause of death | Duration |
|---|---|
| Prematurity | |
| Due to 7 month | |
| Due to pregnancy | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Homer C. Webster M.D.
Address Md Gen Hosp Date signed 12/24/46

VS 150

Huntington

G46816

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

/50

Reg. G46816

Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4112 Edmondson Ave. 28-4
(c) Hospital or institution: nursing home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Chapel Gate Lane ± Old Orchard
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Annie Knabe Roberts

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Howland Roberts
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) October 1870
8. AGE: Years 76 Months 2 Days If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name William Knabe
13. Birthplace Bavaria - Germany

MOTHER
14. Maiden Name Catherine Snyder
15. Birthplace Bavaria

16 (a) Informant John Knabe
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location 3801 Frederick Ave.
18 (a) Funeral director: John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place
19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 23, 1946, at 2:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8, 1946 to Dec. 23, 1946, and that I last saw her alive on Dec. 22, 1946.

| | Duration |
|---|---|
| Immediate cause of death: Cardiac Failure | 1 month |
| Due to: Carcinoma of left breast | 4 years |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard A. Kemp M. D.
Address 3030 Edmondson Ave. Date signed

VS 150

G46817 LEHMAN G46817

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd. & Calvert Sts.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12a
(e) Length of stay in Baltimore (yrs., mos., or days) ?

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County BALTIMORE
(c) City or town TOWSON K3-00
(If outside city or town limits, write RURAL and give town)
(d) Street No. 307 ALLEGHANY AVE. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARY E. LEHMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| FEMALE | WHITE | WIDOWED |

6 (b) Name of husband or wife LEOPOLD LEHMAN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. ?, 1863

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 10 11 | | hr. min. |

9. Birthplace MARYLAND (?) (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name GEORGE A. DEETS
13. Birthplace MARYLAND

MOTHER
14. Maiden Name ANN POFF
15. Birthplace ?

16 (a) Informant HOSPITAL RECORDS
(b) Address 33rd. & Calvert Sts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 26, 1946 (month) (day) (year)
(c) Cemetery or crematory Govans Presbyterian
Location Baltimore, Md.

18 (a) Funeral director John Bourne' Sons
(b) Address Towson, Md.

19 (a) (Date received by local registrar) (b) Huntington Williamsport, Md.

DEC 26 1946

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23, 1946, at 6:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 22, 1946 to Dec. 23, 1946. and that I last saw HER alive on Dec. 23, 1946

| Immediate cause of death | Duration |
|---|---|
| CORONARY OCCLUSION | ? |
| Due to ARTERIOSCLEROTIC HEART DISEASE | ? |
| Due to | |
| Other Conditions HYPERTENSIVE CARDIOVASCULAR DISEASE (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman M. D.
Address Union Memorial Hosp. Date signed Dec 23 1946

X

G46818

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G46818

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 15-1
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Cumberland St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Pumphrey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 49 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name George Pumphrey
13. Birthplace Md

MOTHER
14. Maiden Name Eliza ?
15. Birthplace Md

16 (a) Informant Cornelius Pumphrey
(b) Address 711 Cumberland St

17 (a) Burial (b) Date thereof 12-26-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md

18 (a) Funeral director Monroe H. Kemsley
(b) Address 578 W. Biddle St

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 26 1946

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## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22- 1946, at 11:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ~~accident~~, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature per Wm. J. Neblett, M.D. M.D.
Medical Examiner.

Date signed 12-24-46

G46819

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 137a

G46819 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 638 N. Gilmor
(c) Hospital or institution: 16-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 638 N. Gilmor (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Perry Morton Chase

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | M |

6 (b) Name of husband or wife Lydia D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 1 | 23 | hr. min. |

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Mortician
11. Industry or business

FATHER
12. Name Samuel W. Chase
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Caroline M. Reed
15. Birthplace Baltimore Md.

16 (a) Informant Samuel W. Sullivan Jr
(b) Address 1011 N. Arlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Co. Md.

18 (a) Funeral director Mc Frances A. Donaldson
(b) Address 528 W. Biddle St.

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 24 1946, at 2.18 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/- 1946 to 12/24 1946 and that I last saw h alive on 12/24 1946

Immediate cause of death Hypertension & Renal Failure

| | Duration |
|---|---|
| Due to | 4 |
| Due to | mo |
| Other Conditions | 1 yr |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. J. Hatcher
Address 1775 Pa Ave Date signed 12/27/46

Correct age is especially important. Physician: please write plainly.

VS 8

DEC 28 1946

X

G46820

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

G46820 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1619 N. Bond St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 N. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Edward Ritter

3 (b) If veteran, name war No

3 (c) Social Security Account No. 070-03-4183

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Dilla B.

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1888

8. AGE: Years 58 Months 10 Days 25 If less than one day hr. min.

9. Birthplace Delaware
(Town, county, and state)

10. Usual Occupation Cabinetmaker

11. Industry or business Glenn Martin

FATHER
12. Name Samuel Ritter
13. Birthplace Georgia

MOTHER
14. Maiden Name Manlor
15. Birthplace Georgia

16 (a) Informant Mrs. Dilla Ritter
(b) Address 1619 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 30 46 (month) (day) (year)

(c) Cemetery or crematory Williamsport
Location Williamsport Penna.

18 (a) Funeral director Mowell & Son
(b) Address Williamsport Penna.

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 25 December 1946 at 1 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 24 Dec 1946, to 25 Dec 1946, and that I last saw h[illegible] alive on 24 Dec 1946.

Immediate cause of death Coronary Thrombosis — Duration 20 hrs

Due to Angina Pectoris

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice F. Shull M.D.

Address 1626 N. Carlton Date signed 12-26-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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Registrar for Williamsport, Md.

G46821

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

Registered No. G46821

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 502 S. Washington St
(c) Hospital or institution: 2 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 502 S Washington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Stanievicz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Peter Stanievicz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 2-6-1883

8. AGE: Years 63 | Months 10 | Days 18 | If less than one day: hr. min.

9. Birthplace: Poland
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Jerzy Matya
13. Birthplace: Poland.

MOTHER
14. Maiden Name: ?
15. Birthplace: Poland

16 (a) Informant: Peter Stanievicz
(b) Address: 502 S Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec 27/46 (month) (day) (year)
(c) Cemetery or crematory: Holy Rosary
Location: Baltimore

18 (a) Funeral director: Fred W Ozazewski
(b) Address: 1930 Eastern Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 24 1946, at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1936 to Dec. 24 1946, and that I last saw h[illegible] alive on Dec. 17 1946.

| | Duration |
|---|---|
| Immediate cause of death: Pneumonia | 1 day. |
| Due to: Exhaustion | 3 mos. |
| Due to: Cerebral Arteriosclerosis | 2 yrs. |
| Other Conditions: Diabetes Mellitus | 8-10 yrs. |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Herbert Eldstrom M. D.
Address 2243 Linden Av. Date signed Dec 26, 1946

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

DEC 26 1946

83a

G46822

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48B

Registered No. G46822

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 929 N. Eutaw Street
(c) Hospital or institution: 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town)
(d) Street No. 929 N. Eutaw St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country no.

**3 (a) FULL NAME** Anna Mae Walker

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | colored | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 10 | 16 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Unemployed.
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Ephraim E. Turner
(b) Address 929 N. Eutaw St.

17 (a) Burial (b) Date thereof 12/26/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemet.
Location Cedar Hill Md.

18 (a) Funeral director A. Halstad
(b) Address 918 Druid Hill Ave.

19 (a) Dec 26 1946 (b) Wilson for Williams M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 22, 1946, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec / 1946, to Dec 22 1946, and that I last saw h.. alive on 12/22 1946.

| Immediate cause of death | Duration |
|---|---|
| Myocardiotis | Unknown |
| Due to Carcinoma uterus | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 402 Edmondson Date signed 12/26/46 M. D.

VS 150

646823

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1258

Registered No. 646823

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1928 E. Madison st
(c) Hospital or institution:
7-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1928 E Madison St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Ernest Pridgen

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Col | married |

6 (b) Name of husband or wife Alice Bridgers
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Nov. 24 1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 0 | 29 | hr. min. |

9. Birthplace Rocky Mount N. C.
(Town, county, and state)
10. Usual Occupation Labor, loading trucks
11. Industry or business and unloading

FATHER
12. Name Hallas Pridgen
13. Birthplace Rocky Mount N.C.

MOTHER
14. Maiden Name Sofibia Westrey
15. Birthplace Rocky Mount N.C.

16 (a) Informant Alice Bridgers
(b) Address 1928 E Madison St

17 (a) Ship'd Ed (b) Date thereof 12. 26. 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rockymount N
Location Rocky Mount N C

18 (a) Funeral director P. Farmer Sanders
(b) Address 1412 E. Preston St

19 (a) (b)
(Date rec'd by Registrar) Registrar

VS 3

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23, 1946, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 24 1946, to Dec 23 1946, and that I last saw him alive on Dec 21, 1946.

Immediate cause of death Pneumonia, Hypostatic
Tuberculosis on Meninges of Brain — Duration 11:7:46

Due to Hepatic Enlargement, Hepatitis almost a year, Duration

Due to stopped seeing Whitney in April. Duration

Other Conditions Glandular Tuberculosis could take only a little milk
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. B. Evans M. D.
Address 426 N. Greene Date signed

G46824

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 55c

G46824 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2805 Keyworth Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Forman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Celia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Samuel
13. Birthplace Russia

MOTHER 14. Maiden Name Bessie
15. Birthplace Russia

16 (a) Informant Celia Forman
(b) Address 2805 Keyworth ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-46 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1647 E Balto St

19 DEC 26 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25 19 46, at 10 54 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20 19 46, to 12/25 19 46, and that I last saw h[im] alive on 12/25 19 46

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions Carcinoma of Rectum
Cancerectomy to Lung.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Heinz Beisinger

Address Sinai Hospital Date signed M. 12 D. 25/46

VS 150

G46825

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

Registered G46825

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3611 Wabash Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fannie Shochet

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Jacob
13. Birthplace Russia

MOTHER 14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Chas. Muller
(b) Address 3611 Wabash Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-46 (month) (day) (year)
(c) Cemetery or crematory United Hebrew Cem
Location Washington Boulevard

18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 E Balto St

19 (a) (Date rec'd by registrar) (b) Registrar

Huntington

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1946 at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20, 1946 to Dec 25, 1946 and that I last saw her alive on Dec 25 1946

Immediate cause of death Cardiac failure — Duration

Due to ? Coronary occlusion & myocardial infarction

Due to Arteriosclerosis & hypertension, heart disease

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney Green M. D.
Address Sinai Hospital Date signed 12/27/46

937

VS 150

G46826

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

937

Registered No. G46826

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1823 West North ave
(c) Hospital or institution: 15-L
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1820 W North ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abe Hoffman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Leah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Simon

13. Birthplace Russia

MOTHER 14. Maiden Name Esther

15. Birthplace Russia

16 (a) Informant Leah Hoffman

(b) Address 1823 W North ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-46 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Park Rd & Hamilton St

18 (a) Funeral director Jack Lewis

(b) Address 1439 E. Balto St.

19 (a) (Date rec'd by registrar) (b) Hunter for Miller

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-25-1946, at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1939 to 12-25-1946 and that I last saw h[illegible] alive on 12-25-1946.

Immediate cause of death: Arteriosclerotic Cardio-vascular Disease — Duration several years

Due to:

Due to:

Other Conditions Paralysis Agitans — one year

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature A. A. Grossman M.D.

Address 1109 N. Calvert St Date signed 12/26/46

DEC 26 1946

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G46827.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G46827.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 10 N Wolfe St
(c) Hospital or institution: 8-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 N Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lillian L. Boehm.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John Boehm
6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) Sept 1 c. 1883

8. AGE: Years 63 | Months 3 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER 12. Name John Gable
13. Birthplace Baltimore

MOTHER 14. Maiden Name Mary Miller
15. Birthplace Baltimore

16 (a) Informant John G. Boehm
(b) Address 15 N Wolfe St

17 (a) Burial (b) Date thereof Dec 26-
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Rural

18 (a) Funeral director Leerich Funeral Home
(b) Address 2008 Orleans St

19 (a) DEC 26 1946 (b)
(Date rec'd by registrar) Registrar

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1946 at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21 1946 to Dec 23 1946 and that I last saw h[er] alive on Dec 23 1946

Immediate cause of death Coronary Thrombosis — Duration 2 days
Due to Coronary Arteriosclerosis ?
& Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard Temple M.D.
Address 1001 E Fayette St Date signed 12/27/46

Huntington Williams, M.D.

X

correct age is especially important. Physicians: please write the CAUSES of death clearly and legibly.

G46828

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

46F

Registered No. G46828

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2660 W. North Ave.
(c) Hospital or institution: 15-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2660 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: FRANK LEE OSBORN

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 216-05-7184

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife: Katherine F. Osborn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1900

8. AGE: Years 46 | Months 5 | Days 17 | If less than one day hr. min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual Occupation Mechanic - automobile

11. Industry or business

FATHER
12. Name William Osborn
13. Birthplace U. S. A.

MOTHER
14. Maiden Name Minnie Horne
15. Birthplace U. S. A.

16 (a) Informant Mrs. Katherine F. Osborn
(b) Address 2660 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md,

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 26

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22, 1946, at 10:03 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1946. to Dec 22 1946
and that I last saw h[illegible] alive on 12/22 1946.

| Immediate cause of death | Duration |
|---|---|
| Carcinomatosis | 6 mos. |
| Due to Carcinoma of Liver | ? |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alvin H. Cawthon M. D.
Address 4709 Eudowood Ave Date signed 12/24/46

X

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G46829

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1312

Registered No. G46829

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 631 N. Bentalou St.
(c) Hospital or institution: 16-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 631 N. Bentalou St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** WILLIAM GEORGE HORN

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | no |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | widower |

6 (b) Name of husband or wife Mary Ellen Horn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1860

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 86 | 6 | 11 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation retired machinist
11. Industry or business

FATHER
12. Name Edward Horn
13. Birthplace Germany

MOTHER
14. Maiden Name Henrietta Waxter
15. Birthplace Germany

16 (a) Informant Mrs. John C. Buchewald
(b) Address 631 N. Bentalou St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 12/26/46 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Balto., Md,

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 23, 1946, at 11:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-16-46 19 to 12/23/46 19, and that I last saw h. im alive on 12/23/46 19.

Immediate cause of death Cerebral Thrombosis — Duration 1 week
Due to Cerebral Solerosis
Due to
Other Conditions Senility, Nephritis Chronic
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. D. Meudelis M. D.
Address 651 N. Bentalou Str Date signed 12/23/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

DEC 26 1946

G46830

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

✓ G46830 Registered No. 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6301 Mayflower Road
(c) Hospital or institution: — 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6301 Mayflower Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daisy Helena Haltman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1879

8. AGE: Years 67 | Months 8 | Days 19 | If less than one day hr. min.

9. Birthplace York, York Co. Penna. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Henry Buppe Haltman
13. Birthplace Mt. Joy, Lancaster Co. Penna

MOTHER
14. Maiden Name Sarah Jane Harman
15. Birthplace Harford Co. Md.

16 (a) Informant Harry J. Haltman
(b) Address 6301 Mayflower Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTO., MD.

19 (a) DEC 26 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1946 at approx. 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from October 26 1946 to Nov. 26 1946, and that I last saw h[illegible] alive on Nov. 26 1946.

Immediate cause of death: Coronary occlusion, acute — Duration: Minutes

Due to: Arteriosclerotic cardiovascular disease — Duration: 8 yrs

Due to:

Other Conditions: Thrombophlebitis right cephalic vein — Duration: 3 mos.
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frederick J. Haltman
Address 6100 York Road Date signed 27 Dec '46

Howard R. Mussen, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

G46831

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 97

Registered No. G46831

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1739 Harford Avenue
(c) Hospital or institution: 9-9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1739 Harford Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Bertha I. Livingston

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: William C. Livingston
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) February 21, 1877

8. AGE: Years 69 | Months 10 | Days 2 | If less than one day: ######## hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Eliakim T. Robb
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine E. Hargest
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Urith Lottie Reissland
(b) Address 1739 Harford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 27, 1946 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Avenue

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) ____ (b) ____
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 23rd., 1946 at 10 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1946 to Dec 23 1946, and that I last saw her alive on Dec 21 1946

| Immediate cause of death: | Duration |
|---|---|
| Cardiac Insufficiency | ? |
| Due to: Sen. Arteriosclerosis | ? |
| Due to: | |
| Other Conditions: Carcinoma cause undetermined | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurel L. Green MD
Address 1761 E Lvrtt St Date signed 12/27/46

VS 150

Huntington Williams MD

X

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46832 ✓ 94a Registered No. G46832

G46832

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 13-3
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 204
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 W. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul G. Patrick

3 (b) If veteran, name war: World War 1

3 (c) Social Security Account No. 212-16-9525

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 48 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John S Patrick
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Anna Heilman
15. Birthplace Baltimore Md

16 (a) Informant Walter Patrick
(b) Address 3021 Erdman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 28/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date received by Registrar) 1946 (b) Registrar

DEC 26 1946 Hunter for Williams M.R.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25 1946, at 4:45 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to h.s death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Capt. Landrum M.D.
Medical Examiner.
Date signed 12/25/46

X

G46833

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1946

Registered No. G46833

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Penna (b) County
(c) City or town Wilkesbarre, (If outside city or town limits, write RURAL and give town)
(d) Street No. 290 Phillips St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Alphonso Matuza

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1910

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 36 | | | hr. min. |

9. Birthplace Plymouth Pa (Town, county, and state)

10. Usual Occupation Locomotive Engineer

11. Industry or business U. S. Government

FATHER 12. Name John Matuza

13. Birthplace Slavonski

MOTHER 14. Maiden Name Eva [illegible]

15. Birthplace

16 (a) Informant Mr Matlouski

(b) Address 388 Maine St. Plymouth Pa

17 (a) (Burial, cremation, or removal) (b) Date thereof Dec 26 1946 (month) (day) (year)

(c) Cemetery or crematory St Legaspars

Location Plymouth Pa

18 (a) Funeral director Leo G. Crook

(b) Address 1701-03 N. Patterson Park Ave

19 (a) (Date received by Local Registrar) (b) Registrar

DEC 28 1946

Waiting for Affidavit

VS 181

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec. 25, 1946, at 12:30 A. M.

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH. Fractured Skull.
Intracranial Hemorrhage.
Cerebellar Hemorrhage.

Due to

Other Conditions Fractured ribs (1st to 7th) Lacerations + Burns Burns.

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 12/25/46 at Found: 5 A. M. 5-2

(b) Where did injury occur? R.R. Tracks: Highway

(c) Did injury occur at home, on farm, industrial place, in public place? Private Prop. While at work? No

(d) Means of injury Blunt force.

23. Signature Howard J. Wadsis M.D. Medical Examiner.

Date signed 12-26-46

X

G46834

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

937 ✓

Registered No. G46834

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1428 Argyle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(g) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1428 Argyle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Bailey

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | Col. | W |

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/10/1862

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 84 | 6 | 12 | hr. min. |

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Thomas Bailey
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Bertha Washington
(b) Address 1428 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/46 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md.

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Pressman St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 1946, at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946, to Dec 22 1946, and that I last saw him alive on Dec 22 1946.

Immediate cause of death Congestive Heart Failure — Duration 2 days.
Due to Arterio sclerotic Heart Disease
Due to
Other Conditions Senility.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert L. Moseley Jr. M.D.
Address 2024 Madison Ave. Date signed 12/24/46

VS 150

DEC 26 1946

Herbert L. Moseley Jr

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46835

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

93

G46835

Registered No.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address 16-47

(c) Hospital or institution: Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) Dit

(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md (b) County

(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)

(d) Street No. 1916 Edmondson Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Walter G Sutch

3 (b) If veteran, name war # 1: Walter G. Sutch.

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mable J. Sutch

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-23-1895

8. AGE: Years 51 | Months 3. | Days 2. | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Stripping Clerk.

11. Industry or business G'ds. Meat Dept

FATHER 12. Name Walter G. Sutch

FATHER 13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Mary Hatten

MOTHER 15. Birthplace Balto. Md.

16 (a) Informant Mrs. Mable J. Sutch

(b) Address 314 N. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 27 1946 (month) (day) (year)

(c) Cemetery or crematory Balto. National Cem.

Location Balto - Md.

18 (a) Funeral director Maurice B. Syffe

(b) Address 1600 N. North Ave.

19 (a) (Date received by registrar) (b) Huntington Williams, Registrar

DEC 26 1946

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25 1946, at 9:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature C. A. Pulaski M.D. Medical Examiner.

Date signed 12/25/46

X

G46836

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 171a

G46836 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Maryland.
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 744 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Walter E. Tamolevicz

3 (b) If veteran, name war: yes
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | | | hr. min. |

9. Birthplace (Town, county, and state)
10. Usual Occupation: Shipyard
11. Industry or business

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-46 (month) (day) (year)
(c) Cemetery or crematory: Baltimore National
Location: ~~Manchester Road~~

18 (a) Funeral director: Joseph Tasuneko Jr.
(b) Address: 607 Washington Blvd

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

DEC 26 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24, 1946, at 7.45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture skull
Intracranial hemorrhage
Laceration of scalp
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 4-2
(a) Date of injury 12-24-46 at 6.40 p. M.
(b) Where did injury occur? Fayette near Fremont Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Pediastrian struck by Street car

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed 12-26-46

G46837

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 157E

Registered No. G46837

506773

Please write the causes of death clearly and legibly. Physicians: please write especially important. Give correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Ala. (b) County
(c) City or town Birmingham
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4713 65th St. N.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jack Lotis Roberts.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (d) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-10-46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 4 | 15 | hr. min. |

9. Birthplace Ala. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jack Roberts
13. Birthplace Tenn.

MOTHER 14. Maiden Name Wilma Wilson
15. Birthplace Ala.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 28/46 (month) (day) (year)
(c) Cemetery or crematory Hopewell Cemetery
Location Birmingham Ala

18 (a) Funeral director John A Mitchell Co
(b) Address 400 Eutaw Place

19 (a) DEC 26 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION** P.

20. DATE OF DEATH Dec. 25 1946, at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 22 1946 to Dec 25 1946 and that I last saw him alive on Dec. 25, 1946.

| Immediate cause of death | Duration |
|---|---|
| Cyanotic attacks | |
| Due to Congenital Heart Disease | |
| Tetralogy of Fallot | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George S Palmer M. D.
Address Johns Hopkins Hosp Date signed 12-28-46

VS 150

G46838

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46838 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 419 Druid Hill Ave
(c) Hospital or institution: 11-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 419 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country No.

3 (a) FULL NAME Clementine Griffin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Howard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22 1893

8. AGE: Years 53 | Months 3 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housework.

11. Industry or business

FATHER 12. Name John Cordery
13. Birthplace Unknown

MOTHER 14. Maiden Name Anna nee Jennifer
15. Birthplace Cambridge Md.

16 (a) Informant Howard Griffin
(b) Address 419 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivery
Location Cedar Hill Md.

18 (a) Funeral director A. Halsted
(b) Address 918 Druid Hill Ave.

19 (a) DEC 26 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 23, 1946, at 2.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 5 1946 to Dec 23 1946 and that I last saw h[illegible] alive on Dec 22 1946

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 11 Days |
| Due to | |
| Due to | |
| Other Conditions None | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1176 Eutaw Place Date signed Dec 26

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 190

X

G46839 G46839

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 707 .Y. Alley. 22-1
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 705 .Y. Alley. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country no.

3 (a) FULL NAME Georgianna Bradford (Queen)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Charlie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1903

| 8. AGE: Years | Months | Days | If less than one day, hr. min. |
|---|---|---|---|
| 43 | 9 | 25 | |

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Maryland

MOTHER
14. Maiden Name unknown
15. Birthplace Maryland

16 (a) Informant Charlie Bradford
(b) Address 705 .Y. Alley.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 9 (month) (day) 1946 (year)
(c) Cemetery Mt. Calvary
Location Cedar Hill, Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) DEC 26 1946 (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7, 1946; at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1946, to Dec 7 1946, and that I last saw h[illegible] alive on Dec 7 1946.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | Unknown |
| Due to Hypertension | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James C. Carson M. D.
Address 1016 N. Broadway Date signed 12-9-46

VS 150

G46840 3

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 170 C

Registered No. G46840

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Balto. City
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-0-A
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County.....
(c) City or town Fairfield (If outside city or town limits, write RURAL and give town)
(d) Street No. 906 Hamilton Ave. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Joseph Basilone

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | married |

6 (b) Name of husband or wife Josephine nee Gross

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 3-19-1898

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 48 | 9 | 6 | ....hr. ....min. |

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Peter Basilone
13. Birthplace Italy

MOTHER
14. Maiden Name Unk
15. Birthplace Italy

16 (a) Informant Peter Basilone (son)
(b) Address 8200 Pulaski Highway

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/25/46 (month) (day) (year)
(c) Cemetery or crematory St. Anthonys
Location Fairfield Pa.

18 (a) Funeral director John J Connolly
(b) Address 418 Eastern Ave. Essex 21

19 (a) 26 1946 (Date rec'd by registrar) (b) Hunter for Will Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25/46, at 2:55 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture - base of skull

Due to.....

Other Conditions Fracture of leg bones, multiple bruises & lacerations

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/25/46 at Balto Co. 2.35 a.M.
(b) Where did injury occur? Route 40, Chesaco Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian, struck by automobile

23. Signature Howard J. Mullen M.D. Medical Examiner.
Date signed 12-25-46

X

G46841 2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V170c

Registered No. G46841

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 26-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5521 O'Donnell St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** GEORGE M. PLUMHOFF

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| ? | ? |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | single |

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31 - 1915

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 31 | 10 | 24 | hr. min. |

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Unemployed.

11. Industry or business —

FATHER
12. Name Henry Blumhoff.
13. Birthplace Balto.

MOTHER
14. Maiden Name Louise Diedman
15. Birthplace Balto.

16 (a) Informant William H. Plumhoff.
(b) Address 2203 Sp. Pt Rd.

17 (a) Burial (b) Date thereof 12/28/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Matthews
Location O'Donnell St.

18 (a) Funeral director John F. Connelly.
(b) Address 442 Eastern Ave. Balto (21)

DEC 26 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 191

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec. 24, 1946, at 2.10 P.M.

**21.** I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Ruptured Liver
Intra-abdominal Hemorrhage

Due to

Other Conditions Bruised burns, lacerations & abrasions.
(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-24-46 at 2.30 P. 26-6 M.
(b) Where did injury occur Bonca St. at O'Donnell St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 12-24-46

G46842

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 52B

Registered No. G46842

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3302 Fleet-Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mr. Thomas Edward Casey
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-10-0681

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M. | White | Married |

6 (b) Name of husband or wife Mrs Margaret Casey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 23, 1902

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 44 | 4 | 2 | hr. min. |

9. Birthplace England (Town, county, and state)
10. Usual Occupation Mechanic
11. Industry or business Rustless Iron & Steel Co.

**FATHER**
12. Name Thomas Casey
13. Birthplace England

**MOTHER**
14. Maiden Name Violet Garnett
15. Birthplace England

16 (a) Informant Margaret Casey (Wife)
(b) Address 3302 Fleet St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-28-46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location Herman Hill Rd.

18 (a) Funeral director Charles B. Zeiler
(b) Address 3605 Fait Ave.

19 (a) Filed in Register's Office Huntingtown Williams 11 1947 (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 25 Dec. 1946 at 7.30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 27 Oct 1946 to 25 Dec 1946 and that I last saw h.m. alive on 25 Dec 1946.

| Immediate cause of death | Duration |
|---|---|
| Immediate cause of death Respiratory & Cardiac failure | |
| Due to Long standing Squamous cell Carcinoma of Bladder | |
| Due to Extensive infiltration | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation Nov 26
Major findings of operation: Highly malig infiltrative Ca. of bladder
of autopsy: ✓

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph R. Filardo M. D.
Address 2025 W. Fayette St. Date signed 12/27/46

VS 186

46843

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 97

G46843 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 309 E. North Ave.
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-4
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County ----------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 E. North Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country ----------

**3 (a) FULL NAME** Anna F. Hyde

3 (b) If veteran, name war ----------
3 (c) Social Security Account No. ----------

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband #### J. Gillard Hyde
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ----------

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| About 78 | --- | --- | --- hr. --- min. |

9. Birthplace Fredericksburg, Virginia (Town, county, and state)
10. Usual Occupation None
11. Industry or business ----------

FATHER
12. Name Copt ---- Franey
13. Birthplace Wisconsin

MOTHER
14. Maiden Name Anna Parker
15. Birthplace Virginia

16 (a) Informant Lucille J. Hyde
(b) Address 309 E. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/46 (month) (day) (year)
(c) Cemetery ######## Green Mount
Location Baltimore, Md.

18 (a) Funeral director H. H. Mears & Son
(b) Address 805 N. Calvert St.

19 (a) ---------- (Date rec'd by registrar) (b) Hunting for Williams, Registrar

DEC 26 1946

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 24 1946 at 9 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 6 1946 to Dec. 24 1946 and that I last saw h## alive on Dec. 24 1946.

Immediate cause of death: Generalized arteriosclerosis — Duration: 4 years

Due to: ----------

Due to: ----------

Other Conditions: ----------

(Include pregnancy within 3 months of death)

Date of operation: ----------

Major findings of operation: ----------

of autopsy: ----------

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ----------
(b) Date of occurrence ---------- at ---------- M
(c) Where did injury occur? ---------- (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ---------- While at work? ---------- (Specify type of place)
(e) Means of injury ----------

23. Signature Ford A. Rice

Address 825 E. 41st St. Date signed 12/27/46

G46844

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1706

G46844 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 575 Baker Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Nancy EBBE

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2,

| 8. AGE: | Years | Months | Days | If less than one day |
|---|---|---|---|---|
| | 78 | | | hr. min. |

9. Birthplace Oakland, Howard Co. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Elias Holland
13. Birthplace Howard county, Md.

MOTHER
14. Maiden Name Eliza Cave
15. Birthplace Howard County, Md.

16 (a) Informant Nancy Roberts
(b) Address 1538 N. Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 26/46 (month) (day) (year)
(c) Cemetery or crematory Western Star Cem
Location

18 (a) Funeral director Mrs Katie R. Gilliard
(b) Address 322 N. Schroeder St.

19 (a) DEC 26 1946 (Date rec'd by registrar) (b) Huntington Williamsport Md. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 21, 1946 at 6 45 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry (Autopsy, Inspection or Inquiry), find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Intracranial hemorrhage
Fracture left femur

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-20-46 at 7:45 P. M. 1513
(b) Where did injury occur? North & Smallwood St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury? Pedestrian struck by auto.

23. Signature George L. Mehrill M.D. Medical Examiner.
Date signed 12/23/46

VS 151

G46845

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G46845

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1127 Argyle ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-2
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 Argyle ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Clara King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife John W. King

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) July 1898

8. AGE: Years 48 Months 5 Days If less than one day hr. min

9. Birthplace Wilmington Del (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Sam Dopson

13. Birthplace ?

MOTHER 14. Maiden Name ?

15. Birthplace

16 (a) Informant John W. King

(b) Address 1127 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 26/1945 (month) (day) (year)

(c) Cemetery or crematory Arlington Memorial

Location

18 (a) Funeral director Mr. Katie R. Williams

(b) Address 322 W. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Dec 21 1945 at 4:45 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from 1-25 1945 to 12-31 1945 and that I last saw h[illegible] alive on 12-20 1945

| Immediate cause of death | Duration |
|---|---|
| Hypertension Cardio Vascular Disease | 2 yrs |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Atwell Jones M. D.

Address 5 S. Y Rodgers Date signed 12-21-45

V S 150

G46846 Ritter

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 47c

G46846 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4505 Walther Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Rudolph Ritter

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | W |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct - 20 - 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67? | 2 | 4 | hr. 167 min. |

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Retired Paperman
11. Industry or business Self -

FATHER
12. Name John Ritter
13. Birthplace Germany

MOTHER
14. Maiden Name Adaline Holtze
15. Birthplace Germany

16 (a) Informant Howard Bergerding
(b) Address 4505 Walther Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/46 (month) (day) (year)
(c) Cemetery or crematory Balto
Location East End 1 North Ave

18 (a) Funeral director Lieb & Zeh Inc
(b) Address 403 E. Preston St

19 (a) [illegible] (b) [illegible] Registrar
(Date rec'd by registrar) Huntington Mills, Md.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/24 1946, at 6:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22 1946, to 12/24 1946, and that I last saw h.i.st. alive on 12/24 1946.

| Immediate cause of death | Duration |
|---|---|
| Cardio Respiratory failure | |
| Due to Interior acute cardiac muscular decay, pleural effusion purulent pneu. | |
| Due to Infarct and atelectasis rt. lower lobe, pneumonia, staphylococcus | |
| Other Conditions Rheumatic Endocarditis with infection secondary | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Parker
Address University Hospital Date signed 12/24 M.

VS 190

X

correct age is especially important. Physicians: please write the

G46847

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

164 E

Registered No. G46847

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo.?

**2. USUAL RESIDENCE OF DECEASED:**
(a) State New York (b) County
(c) City or town New York
(If outside city or town limits, write RURAL and give town)
(d) Street No. 167 E 74th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elizabeth Durham Poor

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | married |

6 (b) Name of husband or wife Henry V Poor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 24 1909

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 37 | 3 | 1 | hr. min. |

9. Birthplace Mt Clare N. J.
(Town, county, and state)

10. Usual Occupation ✓

11. Industry or business

FATHER
12. Name Raymond Ewing Durham
13. Birthplace St Louis Mo

MOTHER
14. Maiden Name Eleanor Hubbard Gregory
15. Birthplace Chicago Ill

16 (a) Informant Henry V Poor
(b) Address 167 E 74th St New York City

17 (a) Cremation (b) Date thereof Dec 27 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount Cem
Location Balto. Md

18 (a) Funeral director Henry W Jenkins & Son
(b) Address McCulloh & Richard Sts

19 (a) DEC 26 1946 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 25 1946, at 1:05 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to Intra cranial Hemorrhage

Due to Multiple fractures, lacerations bruises & abrasions.

Other Conditions Acute mental Depression

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death fill in the following:
(a) Date of injury 12-25-46 at 11:30 a. M.
(b) Where did injury occur? Lord Baltimore Hotel Fayette St. side
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Jumped from window

23. Signature Howard J. Wheeler M.D.
Medical Examiner.

Date signed 12-26-46

G46848

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G46848

49a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W Fayette St.
(c) Hospital or institution:
Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 W Baltimore (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Seraphine (Gibay)
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1879
8. AGE: Years 67 Months Days If less than one day hr. min.
9. Birthplace Loeland (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business
FATHER 12. Name Not Known
13. Birthplace " "
MOTHER 14. Maiden Name " "
15. Birthplace " "
16 (a) Informant Dept Record
(b) Address
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-46 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Balto Md
18 (a) Funeral director George A Farley
(b) Address Baltimore & Fayette
19 (a) (Date rec'd by registrar) (b) Registrar

DEC 26 1946

Huntington Williams, Md

## MEDICAL CERTIFICATION

20. DATE OF DEATH 25 Dec. 1946, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 Dec 1946, to 25 Dec. 1946, and that I last saw h in alive on 25 Dec 1946

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure. | |
| Due to Generalized Ca. | |
| Carcinomatosis & Metastases | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation 4 P. Sep 1945

Major findings of operation: Generalized Carcinomatosis (Ca.)

of autopsy:

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph R Liberto M. D.
Address 2025 W Fayette St Date signed 12/25/46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46849

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G46849

PLEASE WRITE PLAINLY, with unfading ink. Write the causes of death clearly and legibly. Use no abbreviations. Give correct age in every case. Physicians: please write the cause of death clearly and legibly. Underline the cause to which death should be charged statistically.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2314 E Baltr st
(c) Hospital or institution: 28
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 514 Drury Lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

**3 (a) FULL NAME** Dr Eugene L Pessagno Sr

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Margaret L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 17 1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 2 | 6 | hr. min. |

9. Birthplace Balt Md (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business
12. Name of FATHER James Pessagno
13. Birthplace Italy
14. Maiden Name of MOTHER Catherine Pessagno
15. Birthplace Italy
16 (a) Informant Dr E L Pessagno Sr
(b) Address 514 Drury Lane
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md
18 (a) Funeral director George A Farley
(b) Address Fulton & Fayette
19 (a) (Filed by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1946 to Dec 23 1946 and that I last saw h[illegible] alive on Dec 23 1946.

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | 6 months |
| Due to | |
| Due to | |
| Other Conditions Cardio-Vascular Heart disease 7 yrs. (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank C. Imanind M. D.
Address 1129 St Paul Date signed Dec 27/46

VS 150

X

G46850

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

82a

Registered No. G46850

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1302 Light St.
(c) Hospital or institution: 27-18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3623 W. Garrison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** CAROLINE AMELIA PLACK

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | single |

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 27, 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 10 | 28 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation retired saleslady
11. Industry or business The Hub

FATHER
12. Name Louis Plack
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Frick
15. Birthplace Germany

16 (a) Informant Mr. Wm. Plack
(b) Address 3623 Garrison Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 12/28/46 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK CEM.
Location BALTO., MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTO., MD.

19 (a) DEC 26 1946 (Date rec'd by registrar) Funeral from Wilkens Ave. M.E.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 25, 1946, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21 1946, to Dec 25 1946, and that I last saw h[illegible] alive on Dec 25 1946.

| Immediate cause of death | Duration |
|---|---|
| Edema of Lungs | 3 hrs. |
| Cardiac asthenia. | |
| Due to | |
| Due to | |
| Other Conditions Cerebral Hemmorhage Left Hemiplegia. | |

(Include pregnancy within 3 months of death)

Date of operation Not Performed
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. L. Lichtenberg M.d.
Address 708 E North Ave Date signed 12/26/46.

VS 150

Death Certificate

G46851 G-66456

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1192

G46851 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Fremont & Madison Avenue
(c) Hospital or institution: Maryland General Hospital 9-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3819 Kimble Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** CHARLES LEWIS Hoffmann

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| ** | ** |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | single |

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| -- | -- | 19 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation --
11. Industry or business --

FATHER
12. Name Charles Rowell Hoffmann
13. Birthplace Cincinnati, Ohio

MOTHER
14. Maiden Name Virginia Kramig
15. Birthplace Cincinnati, Ohio

16 (a) Informant Dr. C. Rowell Hoffmann
(b) Address 3819 Kimble Rd.

17 (a) Cremation (b) Date thereof 12/27/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Crem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTO., MD.

19 (a) DEC 26 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 26th 1946, at 7:20 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/7/1946 to 12/26/1946, and that I last saw h.. alive on 12/26/1946.

| Immediate cause of death | Duration |
|---|---|
| Prematurity | |
| Due to | |
| Due to | 19 days |
| Other Conditions Dysentery. (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. C. Gonzalez M.D.
Address Maryland G. Hosp. Date signed 12/26/46

Please write plainly, with pen or pencil. Physicians: please write the causes of death clearly and legibly. Underlining and correct age is especially important.

VS 150

X

G46852

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13C

G46852 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Sts.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State ..... (b) County .....
(c) City or town ..... (If outside city or town limits, write RURAL and give town)
(d) Street No. 3702 Cedardale Rd. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

15-11

**3 (a) FULL NAME** Francis J. McGreevy

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | -- |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | |

6 (b) Name of husband or wife Edna L. McGreevy
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 16, 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 7 | 8 | ..... hr. ..... min. |

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation storekeeper - retired
11. Industry or business U.S. Navy Yard, Wash., D.C.

FATHER
12. Name A. H. R. McGreevy
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary E. Frailey
15. Birthplace Balto., Md.

16 (a) Informant Mr. John W. McGreevy
(b) Address 3702 Cedardale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/46 (month) (day) (year)
(c) Cemetery or crematory WOODLA WN. CEM.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTO., MD.

19 (a) DEC 26 1946 (Date rec'd by registrar) (b) Evelyn Hilton Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/24/46 19 ..., at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24/1946 to 12/24 1946, and that I last saw him alive on 12/24/1946.

| Immediate cause of death | Duration |
|---|---|
| T. B. Bronchopneumonia (Bilateral) | |
| Due to Old T.B infection Lungs- | 30 days |
| Due to | |
| Other Conditions Parkinson Disease (Include pregnancy within 3 months of death) | |

Date of operation .....
Major findings of operation: .....
of autopsy Same above.-

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....
23. Signature C. E. Gonzales M. D.
Address Maryland G. Hosp. Date signed 12/28/46

PLEASE WRITE PLAINLY, with ink. Underline the cause to which death should be charged statistically. Physicians: please write the causes of death clearly and legibly. Please answer all questions; your certificate may be returned if incomplete. Be sure that the information you give is correct as it is especially important.

VS 150

X

G46853

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G46853 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 28
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3705 Gwynn Oak Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA VIRGINIA KEILBAR

3 (b) If veteran, name war: bobo

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Edward Keilbar, Sr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 10, 1883

8. AGE: Years 63 | Months 1 | Days 15 | If less than one day hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)

10. Usual Occupation: housewife

11. Industry or business

FATHER
12. Name: Richard Sheckells
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Rebecca Hall
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mr. Edward Keilbar, Sr.
(b) Address: 3705 Gwynn Oak Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/46 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: BALTIMORE, MD.

19 (a) DEC 26 1946 (Date rec'd by registrar) (b) Huntington Williams, Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25 1946, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18 1946 to 12/25 1946 and that I last saw h[illegible] alive on 12/25 1946.

Immediate cause of death: Cardiac standstill — Duration

Due to: Diabetes mellitus

Due to: Coronary infarction

Other Conditions: Arteriosclerosis, Cor Pulmonale

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address [illegible] Date signed 12/25 M.D.

PLEASE WRITE LEGIBLY, WITH INK. Fill in all blanks by writing the word or words required, or the word "none" if there is no information to be given. Be sure to write the causes of death clearly and legibly. Physicians: please write the correct age in years, months, days, hours, or minutes, as the case may be. Your accuracy in this matter is especially important.

VS 150

G46854

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1946

G46854 Registered No.

Please write clearly, with ink. Use no abbreviations. Be sure the causes of death are correctly and legibly stated. Physicians: please write the causes of death clearly and legibly. Be sure the cause which is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert + 33rd Sts
(c) Hospital or institution: Union Memorial Hosp 12-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) ?

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2826 N. Calvert (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

**3 (a) FULL NAME** Lulu M. FARRIS

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | W |

6 (b) Name of husband or wife JAMES M FARRIS 6 (c) If alive, give age . years

7. Birth date of deceased (mo., day, yr.) 12/22/7[illegible]

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 0 | 4 | hr. min. |

9. Birthplace INDIANA (Washington) (Town, county, and state)
10. Usual Occupation NONE Housewife
11. Industry or business

FATHER
12. Name JASPER TURNER
13. Birthplace Washington INDIANA

MOTHER
14. Maiden Name ALICE HAWKINS
15. Birthplace Washington INDIANA

16 (a) Informant GLADYS Mc Dargh
(b) Address 2826 N. Calvert

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/26/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Grafton W. Va.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves

19 (a) DEC 26 1946 (Date rec'd by registrar) (b) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/26 1946 at 8.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/17 1946 to 12/26 1946 and that I last saw h[illegible] alive on 12/26 1946

| Immediate cause of death | Duration |
|---|---|
| Renal failure | 9 d |
| Due to Arteriosclerotic heart disease | 10 yrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address Union Mem. Hosp Date signed 12-26-46

G46855 Tr. 107067

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G46855

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 202 E. Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Albert McGuire

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Charlotte J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5th 1890

8. AGE: Years 56 | Months 3 | Days 20 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Conductor
11. Industry or business P.R.R.

FATHER
12. Name Thomas McGUIRE
13. Birthplace Ireland

MOTHER
14. Maiden Name Laura Ege
15. Birthplace Pa.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records )

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Registrar

VS 1 DEC 26 1946 Hunting for Williams, Mr

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec/25/1946 19 , at 6.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec/24/ 1946 to Dec/25 1946, and that I last saw him alive on Dec/25/ 1946

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 1 day |
| Due to | |
| Due to | |
| Other Conditions Pulmonary Tuberculosis (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.
Address Balt. City Hospitals Date signed 12/26/46

83a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46856

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 92 B

G46856 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1325 N Central ave
(c) Hospital or institution: 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No 1325 N Central ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Chambers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22 1875

8. AGE: Years 71 | Months 6 | Days 1 | If less than one day hr. min.

9. Birthplace Blacksstocks, S.C. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name William Chambers
13. Birthplace Blacksstocks S.C.

MOTHER
14. Maiden Name unknown
15. Birthplace Blacksstocks S.C.

16 (a) Informant Mary C. Cooke
(b) Address 1325 N Central ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/27/46 (month) (day) (year)
(c) Cemetery or crematory
Location Blackstocks S.C.

18 (a) Funeral director Joseph B. Locke
(b) Address 1536 N. Central Ave

19 DEC 26 1946 (Date rec'd by registrar) Hunter Williams M.D. Registrar

VS 160

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1946, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1946 to Dec 23 1946, and that I last saw h[illegible] alive on Dec 21 1946

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | Sudden |
| Due to Mental Disturbance | |
| Due to arterio-sclerosis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Fisher M. D.
1642 E Monument St Date Dec 23 1946

PLEASE WRITE PLAINLY, preferably with typewriter. Fill in all blanks. Be sure and give the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

G46857

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 169

Registered No. G46857

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 28-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3903- N. Rogers Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Oswald T. Soderberg

3 (b) If veteran, name war

3 (c) Social Security Account No. 716-05-3497

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Christine E. Soderberg

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) August 15, 1901

8. AGE: Years 45 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Scranton, Pa. (Town, county, and state)

10. Usual Occupation Foreman-car inspectors

11. Industry or business Pa. R.R.

FATHER
12. Name John Soderberg
13. Birthplace Sweden

MOTHER
14. Maiden Name Annie Anderson
15. Birthplace Sweden

16 (a) Informant Mrs. Christine E. Soderberg
(b) Address 3903 N. Rogers Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 28, 1946 (month) (day) (year)
(c) Cemetery or crematory Brynathyn Cemetery
Location Brynathyn, Pa.

18 (a) Funeral director Miles Lawrence
(b) Address 4540 Liberty Heights Ave.

19 (a) DEC 26 1946 Huntington Williams, M.D. Registrar
(Date rec'd by Registrar)

VS 181

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25, 1946, at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fractured skull

Intracranial hemorrhage

Due to Laceration of brain

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 14-1

(a) Date of injury 12-25-46 about 3 p.m.
(b) Where did injury occur? Wilson St. tunnel Pa.R.R.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes.
(d) Means of injury Struck by Pa.R.R.train

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 12/26/46

946858

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH √94a

Registered No. G46858

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 13-6
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 706 Chrisp St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country CRISP ST

3 (a) FULL NAME James E. HAGAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | married |

6 (b) Name of husband or wife Mildred Hagan

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) June 3 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 6 | 21 | hr. min. |

9. Birthplace Maryland. (Town, county, and state)

10. Usual Occupation

11. Industry or business Balmar Corp.

FATHER
12. Name James E. Hagan
13. Birthplace Maryland.

MOTHER
14. Maiden Name Winifred ?
15. Birthplace Maryland.

16 (a) Informant Mildred Hagan
(b) Address 706 Chrisp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 27/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Old Frederick Road.

18 (a) Funeral director Rhenowel & Donovan
(b) Address 3615-17 Edmondson Ave

19 (a) DEC 26 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 24 1946 at 6 a. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 12/24/46

VS 151

X

correct age is especially important. Physicians: please

G46859

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G46859 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use typewriter if possible. Do not abbreviate or use ditto marks. Be sure to write the answer to every question. Where information is unknown or doubtful, write the words "unknown" or "doubtful." Do not write in the space marked "Registered No." Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Green & Lombard Streets
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County City 27-1
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3317 Grenton Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** ELMER G. BENNETT

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1889

8. AGE: Years 56 ~~1744~~ | Months 11 | Days 29 | If less than one day ~~111111~~ min.

9. Birthplace Baltimore, Md. (City, county, and state)
10. Usual Occupation Retired
11. Industry or business Fire Dept. Balto: City

FATHER
12. Name Henry Bennett
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Eliza Cloud
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Isabelle Conderman (Sister)
(b) Address 2824 Belmont Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd. Balto: City

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1755 Harford Avenue

19 (a) ~~DEC 27 1946~~ (Date received by registrar) (b) ____ Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26 1946, at 9:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/26 1946 to 12/26 1946, and that I last saw him alive on 12/26 1946.

Immediate cause of death Cardio resp. failure — Duration

Due to Coronary heart disease

Due to Coronary thrombosis old and recent

Other Conditions Pulmonary embolism

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. G. Gamberg
Address Univ. Hosp. Date signed 12/26/46

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

VS 150

Huntington Williams, M.D.

X

G46860

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 97

G46860 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2725 W. North Ave
(c) Hospital or institution: Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County 15-3
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2725 W. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christopher S. Selenger

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Sarah M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 84 | | | hr. min. |

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Robert L. McDowell
(b) Address 1208 Bolton St

17 (a) Burial (b) Date thereof 12/27/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 129 St. Paul St

19 (a) DEC 27 1946 (b)
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 26th 1946, at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1945 to Dec 26 1946, and that I last saw h alive on Dec. 17 1946

| Immediate cause of death | Duration |
|---|---|
| Uremia | |
| Due to Enlarged prostate c Bedsore Infection | |
| Due to Arteriosclerosis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address 314 McNeal Pl Date signed 12/27/46 M.D.

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information must be answered. If unknown, write "unknown." Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

VS 150

G46861

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46861 Registered No. 1248

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be made for each item. Use additional sheet if necessary. If unknown or if not applicable, write NONE. Physicians: please write the correct age in years, months, days, hours, or minutes, as the case may be, and underline the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 222 N. Hilton St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County 20-7
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 222 N. Hilton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John J. Robinson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband or wife: Ellen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 17th 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 9 | 8 | hr. min. |

9. Birthplace Dublin, Ireland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Special Police

FATHER
12. Name John J. Robinson
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary J. (Unknown)
15. Birthplace Ireland

16 (a) Informant Evelyn V. Mitchell
(b) Address 222 N. Hilton st.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 12/30/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 E. Read St

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 25th 1946, at 8:45 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 22 1946 to Dec 25 1946 and that I last saw him alive on Dec 22 1946

Immediate cause of death: Arteriosclerosis of Liver — Duration: 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis F. Lang M. D.
Address 644 N. Milton Ave Date signed Dec 26, 1946

VS 150

G46852 BC# G64917

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 157a

G46852

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County 6-2
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 120 N. Belnord Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William M. Baker (BAKER)

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) Dec 8th 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 16 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William M. Baker
13. Birthplace Ill.

MOTHER
14. Maiden Name Charlotte Weide
15. Birthplace Balto. Md.

16 (a) Informant William M. Baker
(b) Address 120 N. Belnord Ave

17 (a) Burial (b) Date thereof 12/27/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) DEC 27 1946 (b) Huntington for Williams
(Date rec'd by Registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/24/1946, at 10:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10 1946 to 12/24 1946, and that I last saw h[illegible] alive on 12/24/1946

Immediate cause of death Pneum.
Spina bifida, incl. meningomyelocele
Meningitis, int.
Due to hydrocephalus

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanley Miller M.D.
Address 5 Mun Hgt Date signed 12/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G46863

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46863 No. 122a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. Do not omit any because you consider it unimportant. Cross out words not necessary to describe the case. Where there is no entry, write none. Do not use ditto marks. Be sure to cite the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Broadway + Fairmount Ave
(c) Hospital or institution: Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County City 27-19
(c) City or town Baltimore (15)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5705 East Ave
(If rural give location)
(e) Citizen of foreign country? na (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs. Lillian Kenny.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F. | W. | M. |

6 (b) Name of husband or wife James A. Kenny
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/23 - 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 yr | 11 | 3 | hr. min. |

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

**FATHER**
12. Name John Barron
13. Birthplace Baltimore

**MOTHER**
14. Maiden Name Elizabeth Allen
15. Birthplace Baltimore

16 (a) Informant Patient - Deceased
(b) Address

17 (a) Burial (b) Date thereof 12/28/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director Williams Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (b)
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 1946 at 12:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 19 1946 to Dec 26 1946 and that I last saw her alive on Dec 26 1946.

| Immediate cause of death | Duration |
|---|---|
| Massive Pulmonary Embolism | 0-12 hrs |
| Due to Venous Thrombosis | ? |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation 12/4 & 12/27/46
Major findings of operation: Repair of Diaphragm Hernia - 2. Rep. Thoracic Duct
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.
Address Church Home + Hosp. Date signed 26 Dec 46

DEC 27 1946
Huntington Williams, M.D.

VS 150

X

G46864 BALTIMORE CITY HEALTH DEPARTMENT G46864

# CERTIFICATE OF DEATH 50

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1312 N Lexington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County 10-1
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 E Biddle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mamie F Dorsch

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 4, 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 10 | 22 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name James Donahue

13. Birthplace Ireland

MOTHER 14. Maiden Name Nellie Kilduff

15. Birthplace Baltimore Md

16 (a) Informant Mildred Miller

(b) Address 823 Regester St

17 (a) Burial (b) Date thereof 12/28/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore Md

18 (a) Funeral director Fallon & Doyle

(b) Address 1217 E Fayette St

19 (a) DEC 27 1946 (b) Huntington for Nicholas, M
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 26 1946 at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-8 1946, to 12-26 1946, and that I last saw h er alive on 12-24 1946.

Immediate cause of death: Carcinoma of Breast & generalized metastases — Duration 1½ yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation July 9, 1946

Major findings of operation: Carcinoma of breast

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. McClafferty M. D.

Address 308 E. Lake Ave Date signed 12-26-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the cause of death clearly and legibly.

VS 150

G46865 G46865

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 479

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1726 E. Balto St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County 6-5
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1726 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Howard H. Pearl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Estella Pearl

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 13, 1883

8. AGE: Years 63 | Months 9 | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business

FATHER
12. Name Samuel T. Pearl
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah E. Callow
15. Birthplace Md.

16 (a) Informant Mrs Eva McCall
(b) Address Washington, DC

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/46 (month) (day) (year)

(c) Cemetery or crematory Western
Location Balto. Md

18 (a) Funeral director Geo L Berger Jr
(b) Address 151 2 Hollins St

19 (a) (Date rec'd by registrar) (b) Registrar

VS. 154

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec. 25th 1946, at 7 A. M

**21.** I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Primary Carcinoma of lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

**23. Signature** Howard J. Mudd M.D.
Medical Examiner.

Date signed 12-27-46

G46866

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

X G46866 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland Southern Hotel.
(b) Street address Calvert & Redwood Sts.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State N. Y. (b) County
(c) City ~~or town~~ New York City. V-19
(If outside city or town limits, write RURAL and give town)
(d) Street No. 164 W. 79th. St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER S. ROSENFIELD.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elsie Rosenfield.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1881.

8. AGE: Years 65 | Months 2 | Days 18 | If less than one day hr. min.

9. Birthplace Chicago, Ill.
(Town, county, and state)
10. Usual Occupation Salesman.
11. Industry or business

FATHER
12. Name Henry Rosenfield,
13. Birthplace Unknown.

MOTHER
14. Maiden Name Rose Jacoby,
15. Birthplace Louisville, Ky.

16 (a) Informant Mrs. Elsie Rosenfield,
(b) Address New York City.

17 (a) Rem. & Cremation Date thereof 12.27.46.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Ferncliff Crematory
Location Hartsdale, N.Y.

18 (a) Funeral director David Sonnenborn
(b) Address 1902 Eutaw Place,

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

DEC 27 1946

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1946 at 1.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 46 19 . and that I last saw h[illegible] alive on Dec 27 19 46

Immediate cause of death: Coronary occlusion — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. L. Leitenberg M. D.
Address 708 E. 168th St. Date signed 12/28/46

X

REGARD WRITING AS CRIMINAL, WHEN CARELESS OR INACCURATE. Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G46867

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1946

G46867 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item on or answer to every question must be filled in. Use a typewriter if possible. Do not abbreviate except where directed. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place.
(c) Hospital or institution:
Twilight Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County 13-1
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Alhambra Apts.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

**3 (a) FULL NAME** HARRY J. LEOPOLD.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1868.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 11 | 20 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired China & Glass
11. Industry or business Merchant.

FATHER
12. Name Joseph Leopold,
13. Birthplace Germany.

MOTHER
14. Maiden Name Rosa Weiller,
15. Birthplace Germany.

16 (a) Informant Mr. A. Rosenberg,
(b) Address Riviera Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12.29.46. (month) (day) (year)
(c) Cemetery or crematory Ohab Shalom Cem.
Location Balto. Md.

18 (a) Funeral director Bride Lumbermen & Sons
(b) Address 1902 Eutaw Place.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 194 DEC 27 1946

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 26th. 1946 at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to Dec 26 1946, and that I last saw him alive on Dec 25 1946.

| | Duration |
|---|---|
| Immediate cause of death Hypostatic Bronchopneumonia | 3 days |
| Due to Generalized arteriosclerosis | 15 yrs. |
| Due to Hypertensive Cardio-Vascular disease | 15 yrs. |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert M. Gundersheimer, Jr. M. D.
Address Riviera Apts. Date signed

G46868

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93a

G46868 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett Ave.
(c) Hospital or institution:
Pine Ridge
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County 15-8
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2218 Elsinor Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ANNE HARKER

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | single |

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1863

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 2 | 2 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John Valentine Harker
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth A. Hennig
15. Birthplace Md.

16 (a) Informant Mr. John J. Harker
(b) Address 2213 Elsinor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 27 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1944, to Dec 24 1946, and that I last saw her alive on Dec. 24 1946.

| Immediate cause of death | Duration |
|---|---|
| Acute myocarditis | 3 days |
| with Myocardial collapse | |
| Due to Arteriosclerosis | |
| Hypertension | |
| Due to | |
| Other Conditions Pulmonary edema | |
| Senility | |

(Include pregnancy within three months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. V. Harbold M. D.
Address 4206 Harford Road Date signed 12/27/46

Huntington Williams, M.D.

G46869

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G46869 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3401 Dennison Rd D.O.H
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County 15-11
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3401 Dennison Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** (B. MARGARET MESSERSMITH) B. Margaret Messersmith

3 (b) If veteran, name war: **

3 (c) Social Security Account No.: **

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: PAUL PHILIP MESSERSMITH

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): JAN. 17, 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 11 | 6 | hr. min. |

9. Birthplace: BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation: HOUSEWIFE

11. Industry or business

FATHER
12. Name: GRAFTON T. MAYNARD
13. Birthplace: FREDERICK, MD.

MOTHER
14. Maiden Name: **
15. Birthplace

16 (a) Informant: MR. PAUL P. MESSERSMITH
(b) Address: 3401 DENISON RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/27/46 (month) (day) (year)
(c) Cemetery or crematory: WESTERN CEM.
Location: BALTO., MD.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: BALTO., MD.

19 (a) DEC 27 1946 (Date rec'd by Registrar) (b) Huntington Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23 1937, at 2:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Hypertensive C.V. Disease

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Fabricius M.D.
Medical Examiner.
Date signed 12/26/46

VS 131

X

G46870

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G46870

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore 12-6
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2810 St. Paul Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Bradley G. Rutledge

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Mary Rutledge
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 14th 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 2 | 12 | hr. min. |

9. Birthplace Portsmouth N.H.
(Town, county, and state)
10. Usual Occupation Investigator
11. Industry or business U.S. Internal Revenue Service

FATHER
12. Name Arthur T. Rutledge
13. Birthplace N.H.

MOTHER
14. Maiden Name Georgia Rose
15. Birthplace N.H.

16 (a) Informant Mary Rutledge
(b) Address 2810 St. Paul St.

17 (a) Removal (b) Date thereof 12/27/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory South
Location Portsmouth N.H.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 181

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 26, 1946, at 10.45 A.M.

21. I certify that I took charge of the remains described above, held an Insp.&Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12-26-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46871

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1946

G46871 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4000 Chatham Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County 15-16
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4000 Chatham Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** BARBARA ANNE LANE

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| NO | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widow |

6 (b) Name of husband or wife Samuel Ethan Lane
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 5 | 5 | hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Peter Sanders
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Susanna Harvey Daneker
15. Birthplace Baltimore, Maryland

16 (a) Informant Miss Katherine Sanders
(b) Address 4000 Chatham Road

17 (a) Burial (b) Date thereof 12-30-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Olivet Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) DEC 27 1946 (b) M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/26 1946, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1943 to Dec 26 1946 and that I last saw h[illegible] alive on Dec 25 1946

| Immediate cause of death | Duration |
|---|---|
| Myocarditis | Fatal |
| Arterio-Sclerosis | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W H Roady M.D.
Address 1403 Park Ave. Date signed 12/26/46

V S 130

Huntington

X

G46872

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 178a

G46872 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:** 26-4
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1227 Quantril Way (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Eugene Theis

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| WORLD #2 | 217-18-0637 |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Elaine Forbs Theis
6 (c) If alive, give age 21 years

7. Birth date of deceased (mo., day, yr.) Mar. 24, 1924

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 27 | 9 | 4 | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Steelworker
11. Industry or business Maryland Dry Docks

FATHER
12. Name Phillip P. Theis
13. Birthplace Germany

MOTHER
14. Maiden Name Julie Werslaski
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Elaine Theis-widow
(b) Address 620 N. Belnord Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/46 (month) (day) (year)
(c) Cemetery or crematory Mount Carmel
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) DEC 27 1946 (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25 19 46 at 12:05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to Carbon Monoxide
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-24-46 at 11 P M.
(b) Where did injury occur? 1227 Quantril Way
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Carbon Monoxide Gas from water heater during use not intended or employed

23. Signature H. P. Fabricius M.D. Medical Examiner.
Date signed 12/25/46

VS 151

X 121

G46873

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1316

G46873

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2101 W. Coldspring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County 3-1
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 517 S. Caroline St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Christina D. Rush

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| NO | NONE |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | WIDOW |

6 (b) Name of husband or wife Lawnfield H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 8 | 15 | hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Reader
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace ?

16 (a) Informant Mrs. Lena Ross
(b) Address 517 S. Caroline St.

17 (a) Burial (b) Date thereof Dec. 27, 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Carmel
Location Baltimore Md.

18 (a) Funeral director H. Sander & Sons
(b) Address North Ave & Broadway

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 24 1946 at [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15 1946, to 12/24 1946, and that I last saw her alive on Dec 24 1946.

| Immediate cause of death | Duration |
|---|---|
| CHRONIC GLOMERULAR NEPHRITIS | 5 yrs |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R. Kleiman M. D.
Address 3803 Edmondson Ave Date signed 12/31/46

VS 190

G46874

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G46874 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County 8 6
(c) City or town Baltimore 13.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1636 N. Washington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Caroline Miller (CAROLINE MILLER)

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife John M.
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) August 9, 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 4 | 18 | ..... hr. ..... min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Adam Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Silber
15. Birthplace Baltimore, Maryland

16 (a) Informant Mr. John Michael Miller
(b) Address 1636 N. washington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/46 (month) (day) (year)
(c) Cemetery or crematory paltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12-25- 1946 at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-21 1946 to 12-25 1946 and that I last saw her alive on 12-25 1946.

| Immediate cause of death | Duration |
|---|---|
| Cardio respiratory failure | |
| Due to Myocardial degeneration | |
| Due to Diabetes Mellitus | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hans B Wilde M. D.
Address St Jos Hosp Date signed 12-25-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use typewriter if convenient. Do not use pencil. Be sure to write the causes of death clearly and legibly. Be sure to correct age is especially important. Physicians: please write

VS 150

G46875

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13B

Registered No. G46875

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 229 S Eaton
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County 26-8
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 229 Eaton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Markel

3 (b) If veteran, name war | 3 (c) Social Security Account No. 216-07-4105

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Mary R Markel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29 1885

8. AGE: Years 61 | Months 2 | Days 27 | If less than one day hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business American Can Co

FATHER
12. Name Joseph Markel
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Henleen
15. Birthplace Md

16 (a) Informant Mrs Mary Markel
(b) Address 229 S Eaton St

17 (a) Burial (b) Date thereof Dec 27/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Balto Co Md

18 (a) Funeral director Lilly & Frank Home
(b) Address 2008 Orleans St

19 (a) (b)
(Date rec'd by registrar) Registrar

DEC 24 1946
Huntington Williams

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1946 at 8:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to Dec 24 1946 and that I last saw h~~im~~ alive on Dec 24 1946.

Immediate cause of death: Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene Zeller M.D.

Address 739 Eastern Ave Date signed 12/26/46

X

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G46876

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH √169

Registered No. G46876

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County 7-4
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town)
(d) Street No. 1018 N. Castle Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Keefer M. BIDLE

**3 (b) If veteran, name war**

**3 (c) Social Security Account No.**

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife Ethel Danner
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Aug 19 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 8 4 | 6 | hr. min. |

9. Birthplace Middletown Frederick Md
(Town, county, and state)
10. Usual Occupation Tinsmith
11. Industry or business Penn R.R.

FATHER
12. Name John a Bidle
13. Birthplace Harmony Md

MOTHER
14. Maiden Name Martha A Regner
15. Birthplace Harmony Md

16 (a) Informant Mrs K M Bidle
(b) Address 1010 Castle

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 28/46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Md

18 (a) Funeral director M J Eichorn
(b) Address 106 E Church St

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 27 1946

VS 191

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25, 1946, at 4.05 P.M.

21. I certify that I took charge of the remains described above, held an inspection [redacted] thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull
Intracranial hemorrhage
Due to Fractured neck
Fractured arm
Other Conditions Fractured ribs

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 14/1
(a) Date of injury 12-25-46 at approx. 3 p. M.
(b) Where did injury occur? Wilson St. Tunnel
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Struck by Pa. R.R. train

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12/26/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

64687B

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 92B

Registration No. 6368'77

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 723 Glenwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 723 Glenwood Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Helen R. Spiegel

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife: Magdalena Spiegel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 16, 1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 5 | 7 | hr. min. |

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: General office Clerk
11. Industry or business: Housing Authority of Balto

FATHER
12. Name: Joseph Spiegel
13. Birthplace: Md

MOTHER
14. Maiden Name: Christina Kratz
15. Birthplace: Germany

16 (a) Informant: Magdalena Spiegel
(b) Address: 723 Glenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 27, 1946 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill
Location: Balto. Md.

18 (a) Funeral director: A. Howard Evans
(b) Address: 1420 N. Charles St.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 27 1946

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24, 1946, at 4:20 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1-1939 to 12-24-1946 and that I last saw h/M alive on 12-24-1946

Immediate cause of death: Myocarditis - with Mitral & aortic valvular disease — Duration: 10 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Thomas F. Parker M. D.
Address: 5211 York Rd Date signed: 12/26/46

b46878

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 83a

G46878 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5201 FERNPARK AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5201 FERNPARK AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARETHA C. CARSTENS

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex: FEM.

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife John. CARSTENS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 25 1860

8. AGE: Years 86 | Months 6 | Days 1 | If less than one day hr. min.

9. Birthplace BALTIMORE MD
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name John. A. LIECK
13. Birthplace GERMANY.

MOTHER
14. Maiden Name ? WILKERS
15. Birthplace GERMANY.

16 (a) Informant MRS MINNA LEHMENN
(b) Address 5201 FERNPARK. AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC 28-46 (month) (day) (year)
(c) Cemetery or crematory St Pauls Cem.
Location Violetville Md

18 (a) Funeral director Mrs Chas A G Rohde
(b) Address 121 E West St

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 27 1946 Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 26 1946, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1 1946, to 12-26 1946, and that I last saw him alive on 12-25 1946.

Immediate cause of death: Cerebral Vascular Accident — Duration

Due to: Generalized Arteriosclerosis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos J Abbott M. D.
Address 4509 Liberty Heights Ave Date signed 12-26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

G46879

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G46879 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4304 Kathland Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna B. Devilbiss

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | M |

6 (b) Name of husband or wife Mr. Walter W. Devilbiss
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-27-85

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 7 | 0 | hr. min. |

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert Rempp
13. Birthplace Pa

MOTHER
14. Maiden Name Mary Bittel
15. Birthplace Balto

16 (a) Informant husband
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 30-46 (month) (day) (year)
(c) Cemetery or crematory Loyola Park
Location Balto Md

18 (a) Funeral director Michael A. Rohde
(b) Address 2327 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

**MEDICAL CERTIFICATION** 45

20. DATE OF DEATH 12-27 1946, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-25 1946 to 12-27 1946 and that I last saw her alive on 12-26 1946

Immediate cause of death Heart Failure — Duration

Due to Coronary Infarct

Due to Coronary Sclerosis

Other Conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

25. Signature James V. Mercer, Jr. M. D.
Address Mercy Hosp Date signed

Huntington 12 21 1946

94a

G46880

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 166

G46880 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 123
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2504 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Furman C. Gant

3 (b) If veteran, name war: WW #2

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1918

8. AGE: Years 28 | Months 4 | Days 23 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Frances Gant.

13. Birthplace Va

MOTHER 14. Maiden Name Catherine Blackburn

15. Birthplace Va

16 (a) Informant Francis Gant.

(b) Address 2504 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/46 (month) (day) (year)

(c) Cemetery or crematory Gate-Nat

Location Md

18 (a) Funeral director Geo. H. Kelson

(b) Address 1303 Pressman St

19 (a) DEC 27 1946 (Date rec'd by registrar) Huntington Mitchell Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 25 1946, at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bullet wound of the brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 12/24/46 at 11:45 P. M.

(b) Where did injury occur? 2111 Pennsylvania Ave.

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Firearms

23. Signature Howard J. Madden M.D. Medical Examiner.

Date signed 12-26-46

VS 181

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46881

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G46881 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: West Balto Gen. Hosp.
(a) Baltimore City, Maryland
(b) Street address Jasper & Dukeland
(c) Hospital or institution West Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: 15-6
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2804 Baker St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Costello

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced.

(b) Name of husband or wife John Costello (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 48 | Months | Days | If less than one day hr. min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name George Samaras
13. Birthplace Greece

MOTHER 14. Maiden Name Kleanthe
15. Birthplace Greece

16 (a) Informant John Sikalis
(b) Address 2804 Baker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-46 (month) (day) (year)

(c) Cemetery or crematory Pk Cemetery
Location Windsor Mill Rd.

18 (a) Funeral director Lambros Funeral Home
(b) Address 438-440 E. North Ave.

19 (a) DEC 27 1946 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 Dec. 1946 at 3:20 a M

21. I certify that death occurred on the date above stated, that I attended deceased from 19 Dec 1946 to 27 Dec 1946, and that I last saw h. P. alive on 24 Dec 1946

| | Duration |
|---|---|
| Immediate cause of death: Coronary Thrombosis | |
| Due to: Acute Hepatic Necrosis | |
| Due to: Hot | |
| Other Conditions: Arteriosclerosis | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lester A. Adler M.D.
Address Balto Gen Hosp Date signed 12/27/46

4 tirs for Williams, MD

Hosp 125a

G16882

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1313

G16882 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County 10-1
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 918 E. Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Edward Donovan

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/28/1873

8. AGE: Years 50 | Months 11 | Days 28 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Printer

11. Industry or business Kenedy & Co-Printers

FATHER
12. Name Denis Donovan
13. Birthplace England

MOTHER
14. Maiden Name Mary Weber
15. Birthplace Germany

16 (a) Informant Mrs. Louis Donovan
(b) Address 1037 Hanford Ave

17 (a) Burial (b) Date thereof 2/30/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or ~~crematory~~ Holy Redeemer
Location 4430 Belair Rd.

18 (a) Funeral director Edwin H. Cullen & Son
(b) Address 914 E. Eager St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 151

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec. 26, 1946, at 12.40 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Bilateral Pulmonary Tuberculosis with cavities.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 12-27-46

X

G46883

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 567 X

G46883 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Mercy Hosp
(c) Hospital or institution: Calv. & Lanstroth Pts

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13d.
(e) Length of stay in Baltimore (yrs., mos., or days) 14d.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State W. Va. (b) County ?
(c) City or town Glenville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Newton E Rymer

3 (b) If veteran, name war ?

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M. | W | Married |

6 (b) Name of husband or wife Stella Rymer
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 2 | 18 | hr. min. |

9. Birthplace W. Va.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name William Rymer
13. Birthplace Virginia

MOTHER
14. Maiden Name Phoebe Patton
15. Birthplace W. Va.

16 (a) Informant Self.
(b) Address –

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 28 46 (month) (day) (year)
(c) Cemetery or crematory ? Location Glenville - W. Va

18 (a) Funeral director Stewart Mortuary
(b) Address 1040 Hanover.

19 (a) (b)
(Filed by registrar) Registrar

DEC 27 1946 Huntington, W. Va.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12-26- 1946, at 7.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-20 1946 to 12-26 1946, and that I last saw h.. alive on 12-26 1946

Immediate cause of death Resp. Fail & Pneumonia, Hypostatic — Duration 3 d.

Due to Uterus. Operation removal of Meningioma — 1 d.

Due to from Brain — 12 yrs.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 12-19-46
Major findings of operation: Meningioma of Brain
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William D. Gentry Jr. M. D.
Address 12-26-46 Date signed Mercy Hosp.

G46884

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V 108

G46884 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1018 N. Eden St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County 10 1
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1018 N. Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Edward Eppes

3 (b) If veteran, name war #2
3 (c) Social Security Account No. #21

4. Sex: Male
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Marcella
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 1910

8. AGE: Years: 36 | Months | Days | If less than one day: hr. min.

9. Birthplace: Burkeville Va (Town, county, and state)
10. Usual Occupation: Steel Worker
11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace:

MOTHER
14. Maiden Name: Pinky Virginia Paige
15. Birthplace: Va

16 (a) Informant: Barbara Proctor
(b) Address: 1018 N. Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec 30th (month) (day) (year)
(c) Cemetery or crematory: Beth. National Cem.
Location:

18 (a) Funeral director: Mc Fetridge & Ellicott Dept
(b) Address: 1029 N. Carlton St.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 27 1946

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12-26- 1946, at 4.55 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 12/12 1946 to 12/26 1946, and that I last saw deceased alive on 12/26 1946.

Immediate cause of death: Lobar Pneumonia — 1946 Dec 26

Due to: Infection & Exposure

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Jas. R. Blake M. D.
Address: 1327 N. Central Ave Date signed: 12-26-46.

G46885

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46885
Registered No.

BCD 105468

1312

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County 6-5
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 Orleans St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** James Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife: Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1880

8. AGE: Years 66 | Months 7 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Klias Dorsey
13. Birthplace Md.

MOTHER
14. Maiden Name Caroline Densbury
15. Birthplace Md.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof Dec. 28 '46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location U. G. County

18 (a) Funeral director Mrs. Lott A. Elliott
(b) Address 1129 N. Caroline St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

DEC 27 1946 Hunting for Williams MD

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1946, at 7:20A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 22 1946, to Dec. 24 1946 and that I last saw him alive on Dec. 24 1946.

Immediate cause of death: Pulmonary Tuberculosis — Duration 6 mos.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: No

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Roberson Jr. M. D.

Address Balt. City Hosp. Date signed 12-25-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46886

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G46886 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address D.A.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County 14-1
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 609 W. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Paul H. Spahn

3 (b) If veteran, name war: World War # 1

3 (c) Social Security Account No. 213-20-4464

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Mary Spahn
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1893

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | 2 | 8 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Barber
11. Industry or business

FATHER
12. Name Jacob G. Spahn
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Utzuber
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Walter Spahn
(b) Address 609 W. North avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Chas. J. Evans & Son Inc.
(b) Address 118 W. Mt. Royal Ave.

19 (a) (Date rec'd by registrar) DEC 27 1946 (b) Registrar

VS 181

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25 19 46, at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. L. Sullivan M.D.
Medical Examiner.
Date signed 12/26/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46887 BF G63827

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G46887

TH. 106549 119a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be entered. Leave no answer to be guessed at. Give the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 Days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County 3-1
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 135 S. Spring St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Girl Odom ( Berness Twin B

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 2nd, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 16 | hr. min. |

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

**FATHER**
12. Name Daniel Odom
13. Birthplace S. C

**MOTHER**
14. Maiden Name Berness
15. Birthplace S.C

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records

17 (a) cremated (b) Date thereof 12-23-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto City Hosp
Location 4940 Eastern Ave

18 (a) Funeral director
(b) Address

19 (a) DEC 27 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH December 18th 1946 at 9.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 2nd 1946, to Dec. 18 1946, and that I last saw her alive on Dec. 18th 1946.

| Immediate cause of death | Duration |
|---|---|
| Diarrhea | 6 days |
| Due to | |
| Due to | |
| Other Conditions Prematurity | 17 days |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julian F. Duffin M. D.
Address Balt City Hosp Date signed 27 Dec 1946

VS 150

G46888 alt G62380

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1198

Registered No. G46838

TN. 106193

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County 26-6
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5718 Cardinal Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy Sims ( Rosie

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Col. | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18th 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 1 | 4 | hr. min. |

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Sims Sims
13. Birthplace N. C

MOTHER
14. Maiden Name Rosie
15. Birthplace N.C

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records

17 (a) Cremated (b) Date thereof 12. 23-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto city Hosp
Location 4940 Eastern ave

18 (a) Funeral director
(b) Address

19 (a) DEC 27 1946 (b) Chas. Ashton for Williams, Registrar
(Date rec'd by registrar)

**MEDICAL CERTIFICATION** A.M.

20. DATE OF DEATH December 22nd 1946, at 10.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 18th 1946, to Dec 22 1946, and that I last saw h. im alive on Dec. 22nd 1946.

| Immediate cause of death | Duration |
|---|---|
| Ulcerative Colitis | 5 days |
| Due to | |
| Due to | |
| Other Conditions Prematurity | 1 month |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Ulcerative colitis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julian P. Pfeffer M. D.
Address Balt City Hosp Date signed 24 Dec 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

046889

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1108

Registered No. 046889

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 403 S. East Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County 26-11
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 403 S. East Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Bertha M. Witzke

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | W |

6 (b) Name of husband or wife Frederick G.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 6 | 13 | hr. min. |

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John Schohl
13. Birthplace Germany

MOTHER
14. Maiden Name not known
15. Birthplace Germany

16 (a) Informant Albert Witzke
(b) Address 403 S. East Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/46 (month) (day) (year)
(c) Cemetery or crematory First Evangelical
Location O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) DEC 27 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 25 1946, at 2 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1946, to Dec 25 1946, and that I last saw h. alive on Dec 25 1946.

| Immediate cause of death | Duration |
|---|---|
| Lobar Pneumonia | 5 days. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Mitchelmann M. D.
Address 1040 Madison St Date signed 12/27/46

X

G46890

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G46890 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County 22-1
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 25 W. Lee St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Walter Randolf

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13 1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 Y.M.T | 8 | 12 | hr. min. |

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business —

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Ellen Sutton
(b) Address 702 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/46 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Balto City

18 (a) Funeral director Isaac L Brown & Son
(b) Address 1216 W Montgomery St

19 (a) DEC 27 1946 (Date rec'd by registrar) (b) Interior Utilities Supervisor

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/25/1946, at 10:00 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. S. Palmisano M.D.
Medical Examiner.
Date signed 12/25/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

0 X

G46891

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 166

G46891 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County 5-1
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 26 N. Spring Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Shoffner

**3 (b) If veteran, name war**

**3 (c) Social Security Account No.**

**4. Sex** Male

**5. Color or race** Colored

**6 (a) Single, married, widowed, or divorced.**

**6 (b) Name of husband or wife**

**6 (c) If alive, give age** years

**7. Birth date of deceased (mo., day, yr.)** 1905

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 41 | | | hr. min. |

**9. Birthplace** N. C. (Town, county, and state)

**10. Usual Occupation** Laborer

**11. Industry or business**

FATHER — **12. Name** James Shoffner
**13. Birthplace** N.C.

MOTHER — **14. Maiden Name** Sarah Spinks
**15. Birthplace** N C

**16 (a) Informant** Brown's Funeral Home
(b) Address Greensboro, N C.

**17 (a)** Removal (Burial, cremation, or removal) **(b) Date thereof** 12/27/46 (month) (day) (year)
(c) Cemetery or crematory Greensboro
Location N.C.

**18 (a) Funeral director** Isaiah L. Brown & Son
(b) Address 102 W Montgomery St

**19 (a)** (Date rec'd by registrar) **(b)** Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Dec. 25, 1946, 2.45 a M

**21.** I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

**IMMEDIATE CAUSE OF DEATH** Hemorrhage due to gunshot wound of chest involving lungs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-25-46 2.35 a. M.
(b) Where did injury occur? 23 N. Spring St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms-

**23. Signature** Howard J. Madeira M.D.
Medical Examiner.
Date signed 12-26-46

VS 181

G46892 DUFFINS

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1310

Registered No. G46892

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 705 W. Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Y

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County 4-2
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 705 W. Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ella Duffiers

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Robert Duffiers
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 7 1888
8. AGE: Years 58 Months 6 Days 6 If less than one day hr. min.
9. Birthplace Annapolis Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Lyles
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Bush
15. Birthplace Calvert Co. Md.

16 (a) Informant Theresa Johnson
(b) Address 705 W Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof December 27 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs. K. R. Williams
(b) Address 322 N. Schroeder St.

19 (a) DEC 27 1946 (Date rec'd by Registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1946, at 2.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1946 to Dec 23 1946, and that I last saw h[er] alive on Dec 22 1946.

| | Duration |
|---|---|
| Immediate cause of death Chronic Myocarditis | |
| Due to Hypostatic pneumonia | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1424 W Lee Date signed 12/27/46

V S 150

G46893

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G46893 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County 18-3
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1178 Stockton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ROSA LEE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5 — 18 1859

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| D/M 4/12 | | | hr. min. |

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Rebecca M. Fisher
(b) Address 1093 W. Fayette St.

17 (a) Burial (b) Date thereof Dec. 27, 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Jerome.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) DEC 27 1946 (b)
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 18, 1946 at 9 40 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Hypertensive heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Morrell M.D.
Medical Examiner.

Date signed 12/18/46

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46894 397113

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 49a

Registered No. G46894

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:** 18-1
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 935 Bennett
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Brown
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-29-91

8. AGE: Years 55 | Months 10 | Days 25 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Isaac Lample.
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Cornish
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Dec 29, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director Mrs. Katie R. Wallace
(b) Address 322 N. Schroeder St.

19 DEC 27 1946 (Date rec'd by registrar) (b) Wilmer L. Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1946 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 23 1946 to Dec 24 1946 and that I last saw her alive on Dec 24 1946.

Immediate cause of death: generalized abdominal Carcinomatosis — Duration
Due to: ? ovarian Carcinoma
Due to:
Other Conditions: Ascites, Thrombophlebitis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Carcinomatosis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Felix Rutledge M. D.
Address Johns Hopkins Hosp. Date signed 12/27/46

X

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G46895

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G16895

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 255 North Bruce
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County 19-2
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 255 N. Bruce Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** JAMES M. KENT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Frances Kent

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 25, 1887

8. AGE: Years 59 | Months 8 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Plumbers helper

11. Industry or business

FATHER
12. Name Edward Kent.
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Alice Boozy
15. Birthplace Anne Arundel Co

16 (a) Informant Eva Lollers
(b) Address 255 Bruce St.

17 (a) Burial (b) Date thereof Dec. 28, 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Asbourne Memorial
Location

18 (a) Funeral director Mrs. Hattie R. Williams
(b) Address 322 N. Schroeder Str.

19 (a) (Date rec'd by registrar) (b) Registrar

V# 181

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 12/27/46 19 ... at 7:10 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to Arteriosclerotic Cardiovascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Clay C. Weers M.D.
Medical Examiner.
Date signed 12/25/46

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G46896

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 937

Registered No. G46896

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 411 W. Monument St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County 11-3
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 411 W. Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anita Garrison

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | Colored | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1913

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 33 | 10 | 2 | hr. min. |

9. Birthplace Harrisburg Pa.. (Town, county, and state)
10. Usual Occupation maid
11. Industry or business

FATHER
12. Name Wm. Garrison.
13. Birthplace Harrisburg, Pa.

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Gladys Brown
(b) Address 509 Orford St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 28, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) DEC 27 1946 (Date rec'd by registrar) (b) Katie R. Williams Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 24, 1946, at 9:30a M

21. I certify that I took charge of the remains described above, held an insp.& inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Pulmonary Edema
Chronic Myocardial Degeneration.
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mallonee M.D.
Date signed 12-27-46 Medical Examiner.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 181

G46897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G46897

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County 2 3 3
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Victory House-1708 Light St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Sigmund Openhowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16, 1912

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 34 | 4 | 9 | hr. min. |

9. Birthplace: Water Mill, N.Y.
(Town, county, and state)

10. Usual Occupation: Foreman-building Contracts

11. Residence: 524 Riverside Drive

FATHER
12. Name: Walter Openhowski
13. Birthplace: Poland

MOTHER
14. Maiden Name: Mary Anjeska
15. Birthplace: Poland.

16 (a) Informant: McFarland Funeral Home
(b) Address: West Hampton Beach, L.I.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/46 (month) (day) (year)
(c) Cemetery or crematory Locust Hill
Location South Hampton L.I.

18 (a) Funeral director Wilson & Son
(b) Address 1217 Eutaw St

19 (a) DEC 27 1946 (Date rec'd by registrar) (b) Huntington, L.I. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 25, 1946, at 1.40 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fractured Skull

Due to

Other Conditions: Multiple fractures, lacerations & brain burns.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 25/4

(a) Date of injury 12-25-46 12.50 a. M.
(b) Where did injury occur? Patapsco & Sixth St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pediastrian-struck by auto

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 12-27-46

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46898

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G46898 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hospital for the Women of Md

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs

**2. USUAL RESIDENCE OF DECEASED:** 14-1
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 John St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Elizabeth Kirby

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | S |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible] 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 4 | 22 | hr. min. |

9. Birthplace Baltimore, [illegible] Co., Md
(Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name Joseph H. Kirby
13. Birthplace Limerick, Ireland

MOTHER
14. Maiden Name Mary A. Fitzpatrick
15. Birthplace Cavan, Ireland

16 (a) Informant Miss Agnes Kirby, sister
(b) Address 1619 John St, Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/46 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Govans, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) DEC 27 1946 (Date rec'd by registrar) [illegible] Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 26 Dec 1946, at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 23 Dec 1946, to 26 Dec 1946, and that I last saw h.e.f alive on 25 Dec 1946.

| | Duration |
|---|---|
| Immediate cause of death: Cerebral hemorrhage | 9½ days |
| Due to: Hypertensive cardiovascular disease | Chronic |
| Due to: | |
| Other Conditions: Arteriosclerosis, general (Include pregnancy within 3 months of death) | Chronic |

Date of operation
Major findings of operation
of autopsy: No autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter Buckner M.D.
Address Women's Hospital Date signed 26 Dec 46

VS 2

G46899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G46899 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County — 25 - 3
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2306 Washington Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles W Leinbach

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/27-1867

8. AGE: Years 79 | Months 2 | Days 27 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Theodore Leinbach
13. Birthplace Germany

MOTHER
14. Maiden Name Julia Stangler
15. Birthplace Germany

16 (a) Informant Mrs W Theodore
(b) Address 2306 Wash Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Frederick Rd.

18 (a) Funeral director Edward Loudon
(b) Address 231 Gilmor Blvd

19 (a) DEC 27 1946 (Date rec'd by registrar) (b) Herrington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24 1946, at 11:25 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. F. Sulzbacke M.D.
Medical Examiner.
Date signed 12/26/46

VS 181

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46900

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1467

G46900 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1616 Belmor Ct.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County 15-1
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Belmor Ct (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Walter Dundore Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | N | Married. |

6 (b) Name of husband or wife Dora Elizabeth Johnson
6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) Sept 11, 1909

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 37 35 | 3 | 13 | hr. — min. |

9. Birthplace Charlotte Court House Va (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business C.A.F.

FATHER
12. Name William Johnson
13. Birthplace Charlotte Court House

MOTHER
14. Maiden Name Christine Pollard
15. Birthplace Charlotte Court House, VA

16 (a) Informant Dora E. Marshall Johnson
(b) Address 1616 Belmor Ct

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 27, 19 46 (month) (day) (year)
(c) Cemetery or crematory Family Lot. Charlotte Court House, Va
Location

18 (a) Funeral director Mrs. George N. Hallenbeck
(b) Address 1629 Druid Hill Ave

19 (a) (Date rec'd by registrar) Hunting Registrar

VS 150

## MEDICAL CERTIFICATION

20. **DATE OF DEATH** Dec 24 1946, at 6:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1946, to Dec 24 1946, and that I last saw him alive on Dec 15 1946.

Immediate cause of death Intestinal Obstruction, Pachexia
Arteriosclerosis — Duration 3 mos 3 yrs

Due to Cancer of rectum with metastasis to bladder and abdominal viscera — 3 yrs

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. D. Phifer, M.D.
Address 1422 E. Chase St Date signed 12/24/46

G46901

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G46901 Registered No. 748

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County — 183
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 9 S. Poppleton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Henrietta Waliger (Name given in Hosp — Mrs. Mary Soccio)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced ?

6 (b) Name of husband or wife Louis (?)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 22. 1915

8. AGE: Years 31 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation at Home.

11. Industry or business

FATHER 12. Name Edward Rummey

13. Birthplace Baltimore

MOTHER 14. Maiden Name Nanette Deane

15. Birthplace Baltimore Md

16 (a) Informant Edward Rummey

(b) Address 318 S. Woodyear

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/46 (month) (day) (year)

(c) Cemetery or crematory Meadowridge Cem

Location Waverly Md

18 (a) Funeral director Chas J. Gowan & Son

(b) Address 901-903 W. Baltimore St

19 (a) (Date rec'd by registrar) (b) Huntington W Registrar

DEC 27 1946

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-25 1946, at 10 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-11 1946 to 12-25 1946 and that I last saw h[illegible] alive on 12-25 1946.

Immediate cause of death Acute Aleukemic Monocytic Leukemia — Duration 3 Mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John C. Morrison M. D.

Address Univ. Hospital Date signed 12-25-46

G16902

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1328

Registered No. G16902

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Bennett Lombard
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County 21-2
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 627 Wyeth St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Gorth

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | W |

6 (b) Name of husband or wife late August
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 2 | 30 | hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business at home

FATHER 12. Name Henry C Sachsmann
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Mary Kobrodel
15. Birthplace Germany

16 (a) Informant Mrs Florence Sachsenheimer
(b) Address 129 S Calverton Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/46 (month) (day) (year)
(c) Cemetery or crematory Western Cem
Location Edgewood & Laurens Sts

18 (a) Funeral director John Corrao Son
(b) Address 901-03 Holmes St

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12-26 1946, at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-25 1946 to 12/26 1946, and that I last saw her alive on 12-26 1946.

| Immediate cause of death | Duration |
|---|---|
| (a) Emaciation & Malnutrition | |
| Due to (b) TB of Ca or Heart trouble | |
| Due to (c) | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Y Rosenberg
Address University Hosp Date signed 12-26-46

DEC 27 1946 Huntington Williams, M.D.

X

V2,150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46903 / 937 — Registered No. G46903

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 622 S. Linwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County 1-2
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 622 S. Linwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert P. Turner
3 (b) If veteran, name war: No
3 (c) Social Security Account No. None
4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary
6 (c) If alive, give age 70 years
7. Birth date of deceased (mo., day, yr.) Jan 13 1867
8. AGE: Years 79 | Months 11 | Days 13 | If less than one day ____hr. ____min.
9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name
13. Birthplace Balto.

MOTHER
14. Maiden Name Anna
15. Birthplace Holland

16 (a) Informant Mary Turner
(b) Address 622 S. Linwood Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. end North Ave.
18 (a) Funeral director M. A. E. Disposal Co.
(b) Address Lanvale & Aisquith Sts.
19 (a) DEC 27 1946 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 1946, at 11:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-15 1946, to 12-26 1946, and that I last saw h[illegible] alive on 12-26 1946.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Thrombosis | 1½ hrs |
| Due to Chr. Myocarditis | ? |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. J. Davison M. D.
Address 3218 Eastern Date signed 12-27-46

VS 150

Huntington Williams, M.D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-99061 G46904

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G46904

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10Mo.-21days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 Gilmore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Paul Mackall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9- 1918

8. AGE: Years 28 | Months 1 | Days 17 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John
13. Birthplace Maryland

MOTHER
14. Maiden Name Letha
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-46 (month) (day) (year)
(c) Cemetery or crematory Patapsco
Location Calvert Co.

18 (a) Funeral director P.E. Sewell
(b) Address Prince Frederick Md

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 27 1946

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 19 46 at 4.10A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-5- 19 46 to 12-26 19 46 and that I last saw h im alive on 12-26- 19 46

Immediate cause of death Pulmonary Tuberculosis Far Advanced — Duration 2 years

Due to

Due to

Other Conditions Tuberculous Emphysema and Peritonitis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same, plus pulmonary temoval

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J.G. Bird M. D.
Address Balto City Hosps Date signed 12-27-46

G46905

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

83a X

Registered No. G46905

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3d.
(e) Length of stay in Baltimore (yrs., mos., or days) 55yr.

**2. USUAL RESIDENCE OF DECEASED:** 53-00
(a) State Md. (b) County Baltimore
(c) City or town Baltimore DUNDALK
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2546 Liberty Parkway
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Hasse, Albert E. F. (Albert Emil Frederick Hasse)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 217-07-1648

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Ida Hasse

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) NOV. 31 1879

8. AGE: Years 67 | Months 0 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Boiler Maker

FATHER
12. Name George Hasse
13. Birthplace Germany

MOTHER
14. Maiden Name Bertha Fahrwald
15. Birthplace Germany

16 (a) Informant Mrs. A. L. Roth
(b) Address 2922 Rosalie Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-46 (month) (day) (year)

(c) Cemetery or crematory Schwartz
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

VS 150

DEC 27 1946

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Dec. 26 1946, at 1007 M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec. 24 1946 to Dec 26 1946, and that I last saw him alive on Dec. 26 1946.

Immediate cause of death Cardiac failure
Intestinal Obstruction,
Cerebral Accident

Due to ____

Due to ____

Other Conditions ____

(Include pregnancy within 3 months of death)

Date of operation Not

Major findings of operation: Peritonitis due to

of autopsy: Mesenteric thrombosis

Duration: 4 days, 4 days

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury ____

**23.** Signature John D. Rowan M. D.
Address Church Home Hospital Date signed ____

X

G46906

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 47c

G46906 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:** 16-7
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 124 N. Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** WILLIAM L. STRUMSKY

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3-1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 4 | 23 | hr. min. |

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Patrolman - Retired
11. Industry or business U.S. Mail

FATHER
12. Name J. Louis Strumsky
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Harold
15. Birthplace Maryland

16 (a) Informant Mrs. Emma A. Strumsky
(b) Address 124 N. Poplar Grove St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 29 Dec 46 (month) (day) (year)
(c) Cemetery or crematory Stone Chapel
Location Maryland

18 (a) Funeral director F. B. Tiffel & Son
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 27 1946 Huntington Md

VS-150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12-26-1946, at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-24-1946 to 12-26-1946, and that I last saw h. alive on 12-26-1946.

Immediate cause of death Cardio resp. failure — Duration

Due to Bronchopneumonia of R. mid & lower lobe & atelectasis

Due to Hyp. chr. valvular, enteric sclerosis complicating & A.C.V.D.

Other Conditions Intestinal obstruction
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Bowers M. D.
Address Univ. Hosp. Date signed 12-27-46

X

G46907

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a Reg. G46907

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 250 N Monroe St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland County 20-1
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 250 N. Monroe Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles W. Warner

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-01-3935

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Irene E.

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) 2/23/1885

8. AGE: Years 61 | Months 10 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Dry Cleaner

11. Industry or business Carp & Queen

FATHER
12. Name William A. Warner
13. Birthplace Mass.

MOTHER
14. Maiden Name Laura Wigglesworth
15. Birthplace Maryland

16 (a) Informant Mrs. Ida E. Warner
(b) Address 250 N. Monroe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 28, 1946 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park
Location Woodlawn Road

18 (a) Funeral director F. B. Wippert & Son
(b) Address 1304 Luther Place

19 (a) ____ (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 25 1946, at 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 11, 1943, to Dec. 25 1946, and that I last saw him alive on Dec 25 1946

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 1 Day |
| Due to Arterial Hypertension | 3 yrs. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gaye A. Kemp M.D.
M. D.
Address 331 Edmondson Ave Date signed 12/27/46

X

G46908

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1946

G46908

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2510 Greenmount Ave.
(c) Hospital or institution: Southern Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:** 12-3
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2510 Greenmount Ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lizzie Trew

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1863

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 6 | 13 | hr. min. |

9. Birthplace Chestertown, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William G. Trew
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Wilkins
15. Birthplace Md.

16 (a) Informant Thomas William Trew
(b) Address 319 Tunbridge Road

17 (a) Burial (b) Date thereof 12/28/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery St. Paul's
Location Chestertown, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (b)
(Date rec'd by registrar) Registrar

DEC 27 1946

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 26, 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 10 1946, to Dec 26 1946, and that I last saw h alive on Dec 25 1946.

Immediate cause of death

Due to Chronic Myocarditis

Due to old age

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

| Duration |
|---|
| several years |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert C. Blake M. D.
Address Medical Arts Bldg. Date signed

G46909

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. G46909

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2510 Greenmount Ave.
(c) Hospital or institution: Southern Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:** 1213
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2510 Greenmount Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Sarah Evans

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| female | white | single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1855

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 91 | 10 | 10 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Charles D. Evans
13. Birthplace Baltimore

MOTHER
14. Maiden Name Anna M.
15. Birthplace Baltimore

16 (a) Informant Dr. George H. Evans
(b) Address 5734 Pimlico Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/46 (month) (day) (year)
(c) Cemetery ~~Greenmount~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1906 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** December 27 1946, at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3. 1946, to Dec 27, 1946, and that I last saw h[illegible] alive on Dec. 26 1946.

Immediate cause of death — Duration

Due to Chronic Interstitial Nephritis — many years

Due to Chronic Nephritis

Other Conditions Old age

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thurlert C Blake M. D.
Address Medical Arts Bldg. Date signed

VS 130

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46910

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 50

G46910 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Md. Gen. Hosp.
11-25-46 to 12-26-46
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County 27-10
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 805 Winston Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adeline Scott Wood

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | |

6 (b) Name of husband or wife Edwin C. (Deceased)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 24, 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 10 | | hr. min. |

9. Birthplace Conn.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name William W. Scott

13. Birthplace Bristol Conn.

MOTHER 14. Maiden Name Adelia Ford

15. Birthplace Concord N.H.

16 (a) Informant Col. William H. Wood

(b) Address 2747 Ordway St., Wash., D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/46 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville, Md.

18 (a) Funeral director John M. Tschudy & Sons, Inc.

(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26-46 19 at 5 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-25-46 19 to 12-26 19 46, and that I last saw h[illegible] alive on 12-26-1946

| Immediate cause of death | Duration |
|---|---|
| | |
| Due to Carcinomatosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

over

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Simon C. Webster M. D.

Address Md. Gen. Hosp. Date signed 12-26-46

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46911

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 192c

Registered No. G46911

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1402 Caroline St.
(c) Hospital or institution:
St Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt 19-1
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 E 2 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura A Moran

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 26, 1899

8. AGE: Years 47 | Months 1 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Richard T Moran

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Catherine B Wilhelm

15. Birthplace Baltimore Md

16 (a) Informant William J Moran

(b) Address 2007 Ramsay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 29/46 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem

Location S Wolfe Ave

18 (a) Funeral director John C Mc Govern

(b) Address 3600 Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 27 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27th 1946 at 4:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1946 to Dec 27 1946 and that I last saw h-- alive on Dec 27th 1946

| Immediate cause of death | Duration |
|---|---|
| Cardio-Pulmonary Insufficiency due to | |
| Due to Congestive degeneration due to Rheumatic Valvular | |
| Due to Heart Disease | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.

Address St Jos Hospital Date signed 12/27/46

Dr. Fritz Kämzek
2700 Harford Road

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G46912

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1711 Abbottson Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 Abbottson Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Marie Angel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1892

8. AGE: Years 54 Months 3 Days 8 If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Thomas H. Angel
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Rosenberger
15. Birthplace Md.

16 (a) Informant Mr. William H. Angel
(b) Address 1711 Abbottson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 27 1946 Huntington Williams

WS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26th, 1946 at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1920 to DEC 26 1946 and that I last saw h[illegible] alive on DEC 26 1946.

Immediate cause of death

Cardio-renal disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

| Duration |
|---|
| 14 yrs |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fritz J. Kämzek M.D.
M. D.
Address 2700 Harford Road Date signed DEC 27 1946

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G16913 BC# G54895

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 1119a X

Registered No. G16913

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully recorded. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County 53-00
(c) City or town Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. 14 E. Hickman
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Thomas George

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/1946

8. AGE: Years | Months: 4 | Days | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/1946 (month) (day) (year)
(c) Cemetery or crematory Susquehanna
Location Susquehanna Pa

18 (a) Funeral director Lilly & Zeiler Co.
(b) Address 403 S. Wolfe St.

19 (a) 12-27-1946 (Date rec'd by registrar) (b) Hunterstown Williams M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec 26 1946 at 3:55 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1946 to Dec 26 1946, and that I last saw h[illegible] alive on Dec 26 1946.

| Immediate cause of death | Duration |
|---|---|
| ? Cerebral Thrombosis | |
| Acute hemorrhagic disease | |
| Due to with severe dehydration and acidosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23.** Signature Herbert Zimmerman M. D.
Address Johns Hopkins Hospital Date signed 12-30-46

X

G46914

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 107

G46914 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Sts
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Carroll
(c) City or town Sykesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanor Hope Wright

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 9-28-46

8. AGE: Years — | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Sykesville Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Herbert Wm. Wright
13. Birthplace Md.

MOTHER
14. Maiden Name Edna Pauline Hollan Berry
15. Birthplace Md.

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-46 (month) (day) (year)
(c) Cemetery or crematory Springfield Cem.
Location Sykesville, Md.

18 (a) Funeral director C. Harry Weer
(b) Address Sykesville, Md.

19 DEC 28 1946 (Date rec'd by registrar) Certificate for Williamsville, Md.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27th 1946, at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27th 1946 to Dec 27th 1946, and that I last saw her alive on Dec 27th 1946

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Acute Lupus E Erythematosus Pneumonia | 8 hrs. |
| Due to (Collateral) | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. E. Gonzalez M.D.
Address Maryland Gen Hosp Date signed 12/27/46

VS 150

G46915
506393

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G46915
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1739 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME G. Porter Houston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or divorced: Widowed

6 (b) Name of ~~husband or~~ wife: Estelle Houston

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-15-1884

8. AGE: Years 62 | Months 6 | Days 12 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Insurance Business

11. Industry or business Exec. U.S.F. & G. Co

12. FATHER'S Name G. Porter Houston

13. Birthplace Pa.

14. MOTHER'S Maiden Name Mary Ellen Hutton

15. Birthplace Pa

16. (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 12/28/46
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Congressional
Location Washington D. C.

18 (a) Funeral director Milbidge Cook Inc.

(b) Address 217 St. Paul St.

19 DEC 28 1946 (Date accepted by Registrar) Interring for Milbidge Cook Inc. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1946 at 1.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 1946 to Dec. 27 1946 and that I last saw him alive on Dec. 27 1946.

| Immediate cause of death | Duration |
|---|---|
| Myocardial infarction | |
| Due to Arteriosclerosis | 1 |
| Due to | |
| Other Conditions Diabetes Mellitus ? | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature. Maurice B Winstead M.D.

Address J H H Date signed 27 Dec 46

VS 150

94a

G46916

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G46916

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital Hosp'l
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Arrendale Hotel
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard B. JAMISON, JR.

3 (b) If veteran, name war: W. W. #2

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Margaret Estelle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 17 1903

8. AGE: Years: 43 | Months: 6 | Days: 9 | If less than one day: hr. min.

9. Birthplace: Phila Pa
(Town, county, and state)

10. Usual Occupation: Salesman

11. Industry or business

FATHER
12. Name: Howard B. Jamison
13. Birthplace: Pa

MOTHER
14. Maiden Name: Unknown
15. Birthplace:

16 (a) Informant: Dorothy Rosenthal
(b) Address: 3242 Belmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~: U. S. National
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St

19 (a) DEC 28 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26- 1946, at 11 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Acute Pulmonary edema

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Geo. G. Merrill M.D.
Medical Examiner.
Date signed 12/27/46

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46917

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G16917

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lexington Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7 East. Centre Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** FREDRICK BIESMANN

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| None | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 1 | | hr. min. |

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Rose Forte
(b) Address 7 East Centre Street

17 (a) Burial (b) Date thereof Dec. 27, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Meh. Park
Location Parkville, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) DEC 28 1946 Huntington for Williams M.D.
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 1946, at 9:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 23 1946 to Dec 26 1946 and that I last saw him alive on Dec 26 1946

| Immediate cause of death | Duration |
|---|---|
| General Cerebral Sclerosis | 10 yrs |
| Chronic Myocarditis | 10 yrs |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nelson L. Solomon
Address 129 S. Bond Date signed 12/27/46 M. D.

VS 150

G46918 Ford Collection G-63806

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

160a

X G46918 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Rayner & Dukeland
(c) Hospital or institution: West Balto Gen Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 14

**2. USUAL RESIDENCE OF DECEASED:** 53-00
(a) State Md. (b) County BALTO
(c) City or town Baltimore MIDDLE RIVER
(If outside city or town limits, write RURAL and give town)
(d) Street No. 51 Edgewater Apts. West Balto. Gen. Hosp.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Diane Cunningham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Baby

6 (b) Name of husband or wife ****

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1946

8. AGE: Years | Months | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business "

FATHER
12. Name Thomas B. Cunningham
13. Birthplace Nashville Tenn.

MOTHER
14. Maiden Name Elizabeth Puryear
15. Birthplace Reighley N. C.

16 (a) Informant Thomas B. Cunningham
(b) Address 51 Edgewater Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12.28.46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

DEC 28 1946 (Date rec'd by registrar)

(b) [illegible] for Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 27 Dec 1946 at 4 30 M

21. I certify that death occurred on the date above stated, that I attended deceased from 13 Dec 1946 to 27 Dec 1946 and that I last saw her alive on 27 Dec 1946.

Immediate cause of death: Congestive Failure
Due to: Bronchial Pneumonia
Due to: Poor Intake
Other Conditions: Hemorrhage

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

| Duration |
|---|
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leslie A. Sheep Jr. M. D.
Address Dear Baltimore Md. Date signed

Stop. X

VS 150

G46919

SHIPMAN

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1112

G46919

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 629 S. Hanover st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME C. Clyde Shipman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1915

8. AGE: Years 31 | Months | Days | If less than one day hr. min.

9. Birthplace Alabama
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Paul Shipman
13. Birthplace ala

MOTHER
14. Maiden Name Gertrude Smith
15. Birthplace ala

16 (a) Informant Gertrude Smith
(b) Address 200 W. Camden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31-46 (month) (day) (year)
(c) Cemetery or crematory Louisville
Location Alabama

18 (a) Funeral director James A Davis
(b) Address 142 Westill St

19 (a) DEC 28 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

## MEDICAL CERTIFICATION

55

20. DATE OF DEATH 12/26th 1946, at 1 A.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Lis death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute pulmonary edema

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.

Date signed 12/26/46

G46920

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G46920 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5941 Falls Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 28 years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5941 Falls Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Josephine Bryan
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Howard M. Bryan, Sr.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 17-1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 2 | 8 | hr. min. |

9. Birthplace Brooklynville, Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John L. Bowen
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary C. Krueger
15. Birthplace Maryland

16 (a) Informant Howard M. Bryan Sr.
(b) Address 5941 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 28-1946 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 DEC 28 1946 (Date rec'd by registrar) Huntington Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1946 at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Dec 25 1946, and that I last saw her alive on Dec 25 1946

| Immediate cause of death | Duration |
|---|---|
| DIABETES MELLITUS | About 6 mos. |
| Due to | |
| Due to | |
| Other Conditions CARDIAC DEGENERATION | Several Years |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edw Hoffman M.D.
Address 8 East Read St Date signed 12/26/46

M. D.

VS 150

Spec.—9 30—A. & Co.—250 Blks.

G46921

# HEALTH DEPARTMENT—CITY OF BALTIMORE

G46921

## CERTIFICATE OF DEATH.

108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 719 Dolphin 17-3 St. ..... Ward)

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Brown

(a) RESIDENCE No. 719 Dolphin St., ..... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How Long in U. S., if of foreign birth? yrs. mos. ds.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | Colored | Widow |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 7, 1906

| 7 AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 40 | 9 | 12 | |

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cooks
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Bessie Johnson (Address) 513 Carlton St

15 DEC 28 1946 Filed ..... Registrar Huntington Williams M.D.

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 24-46

17 I HEREBY CERTIFY, That I attended deceased from Dec. 8- 1946, to Dec 22 1946
that I last saw her alive on Dec 22 1946
and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY .....
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death? At Place of death
Did an operation precede death? No Date of .....
Was there an autopsy? No Clinical
What test confirmed diagnosis?

(Signed) S B Hughes M. D.
(Address) 1413 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

| 19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL |
|---|---|
| Mt. Auburn Cem. | 12 28 1946 |

20 UNDERTAKER Mrs Frances A. Hemsley

ADDRESS 519 W. Biddle St

TION is very important. See instructions on back of certificate

G46922

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓167

G46922 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Hospital (Provident) 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 Argyle Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Pearsall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-1-1915

8. AGE: Years 31 | Months - | Days 24 | If less than one day hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James W. Pearsall
13. Birthplace N C

MOTHER
14. Maiden Name Isabell Fuller
15. Birthplace N C

16 (a) Informant Elizabeth Pearsall
(b) Address 1212 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-46 (month) (day) (year)

(c) Cemetery or crematory
Location Wilmington N. Carolina

18 (a) Funeral director Mrs. Frances A. Ortmeyer
(b) Address 578 W. Biddle St.

19 DEC 28 1946 (Date received by registrar) Huntington Williams, M.D.

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 1946, at 4:15 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Stab-wound of left brachial artery

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-25-46 at 3:45 P M.
(b) Where did injury occur? 1212 Argyle Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Sharp Instrument

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 12/26/46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46923

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 58B

Registered No. G46923

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: Green & Lombard Streets
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 8 days
(e) Length of stay in Baltimore (yrs., mos., or days): Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: Md (b) County: —
(c) City or town: Baltimore - 6
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 4109 Marx Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Thomas Gracey (Thomas William Gracey)

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: 214-24-3875

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 25, 1928

8. AGE: Years: 18 ### Months: 3 Days: 2 If less than one day: ### hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: School-boy

11. Industry or business:

FATHER
12. Name: Hugh W. Gracey
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Helen A. Gildenfenney
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mr. Hugh W. Gracey
(b) Address: 4109 Marx Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12/30/46 (month) (day) (year)
(c) Cemetery or crematory: Morelands Park
Location: Taylor Avenue, Balto: Co

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1725 Harford Avenue

19 DEC 28 1946 (Date rec'd by registrar) (b) Huntington Williams Mick Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-27 1946, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-19 1946, to 12-27 1946, and that I last saw h[illegible] alive on 12-27 1946.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 18 Days |
| Subarachnoid Hemorrhage | 18 Days |
| Due to: Hypertension | |
| Due to: Rheumatic C.V.H.D. | 15 yr(s) |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John C. Morrison M.D.
Address: Univ. Hosp. Date signed: 12/27/46

VS 150

G46924

Chenoweth

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G46924 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette
(c) Hospital or institution:
Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1927 W. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Chenoweth, Howard

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 10, 1892
8. AGE: Years 54 | Months 5 | Days 15 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation General Work
11. Industry or business

FATHER
12. Name Richard T. Chenoweth
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Elizabeth Dorsey
15. Birthplace Baltimore, Md.

16 (a) Informant William Chenoweth
(b) Address 1927 W. Lombard St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road
18 (a) Funeral director Lowry N. Bligh Jr.
(b) Address 4914 Belair Road
DEC 28 1946 (Date filed by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 25 1946, at 2:05 p. M
21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 6 1946, to Dec. 25 1946, and that I last saw him alive on Dec. 25 1946.

| Immediate cause of death | Duration |
|---|---|
| Fat Embolism due to fracture a | |
| Pulmonary embolism ? | |
| Due to Coronary occlusion ? | |
| Due to | |
| Other Conditions Incomplete fracture of left femur | 19 days |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 20 3
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Dec. 6 at 5:45 P. M
(c) Where did injury occur? Baltimore, Md. 202 Fallsway
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public - Jaeger (M) While at work? Yes
(Specify type of place) Slow of Farm (NW)
(e) Means of injury Fell on sidewalk
23. Signature Nathan Wolf
Address 3804 Pk Hts Ave Date signed Dec 27/46

For Dr. J. Lubinski, by Howard L. Mallett, M.D. X

G46925 Tugwell

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1469

G46925 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Eaton Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3157 Leeds Av. 29,
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs. Anna Tugwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 6 | 25 | hr. min. |

9. Birthplace (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name deceased

13. Birthplace

MOTHER 14. Maiden Name Anna Muth

15. Birthplace

16 (a) Informant Mrs Joseph ~~Tugwell~~ Eyer.

(b) Address 3157 Leeds Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 28 '46 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location 3401 Frederick Rd

18 (a) Funeral director Harry W Witzke

(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

DEC 28 1946

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/25 1946, at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10 1946 to 12/25 1946 and that I last saw he alive on 12/25 1946.

| Immediate cause of death | Duration |
|---|---|
| Biliary obstruction with secondary liver damage | |
| Due to Carcinoma of the head of the | ? |
| Due to pancreas. | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation 12/18/46

Major findings of operation: Carcinoma at the head of the pancreas.

of autopsy: not performed.

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert J. Lenckos M.D.

Address St. Agnes Hospital Date signed 12/25/46

G46926

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48 B

Registered No. G46926

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1501 W. Lombard ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 W. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Sarah C. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband ~~or wife~~ Joseph Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 1 | 3 | hr. min. |

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Gilbert Crockett
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Rayfess
15. Birthplace Virginia

16 (a) Informant alice Crockett Hunt
(b) Address 1501 W. Lombard ST

17 (a) Burial (b) Date thereof Dec 28 '46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Matthews
Location Gwynnes Island - Matthews Va.

18 (a) Funeral director Harry H. Wright
(b) Address 4101 Edmondson Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

DEC 28 1946 Huntington Hillsville, Md

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 27 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 25, 1946 to Dec. 27 1946, and that I last saw her alive on Dec 25, 1946

| Immediate cause of death | Duration |
|---|---|
| Metastatic Carcinoma of Uterus | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abram Goldman M.D.
Address 3834 Pk. Hts. Ave. Date signed 12/27/46

X

G46927

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 148a

Registered No. G46927

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4602 Glenarm Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4602 Glenarm Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charlotte A. Overside

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Conrad H. Overside
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 11 | 28 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name James S. Lamb
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Mary Edmeades
15. Birthplace Mass

16 (a) Informant Mrs. Fredk. Franke
(b) Address 4602 Glenarm Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md.

18 (a) Funeral director Lansdale Funeral Home
Address 7401 Belair Rd.

19 (a) DEC 28 1946 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27th 1946, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1946 to Dec 27 1946 and that I last saw h alive on Dec 27, 1946.

Immediate cause of death Acute Heart Failure — Duration 1 Day.
Due to Carcinoma of Cervix — 1 year
Due to
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature John Dyer, M. D.
Address 516 Virlen Date signed 12/28/46

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

VS 150

C46928

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

93D

Registered No. C46928

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 703 S Eaton, St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 703 S. Eaton, St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** JOSEPH H. MORGERETH

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Widowed |

6 (b) Name of husband or wife Ursaline Schmidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 10 | 12 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Street Sweeper
11. Industry or business B.S.C.

FATHER
12. Name Joseph H. Morgereth
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Gerard Morgereth
(b) Address 703 S. Eaton, St.

17 (a) Burila (Burial, cremation, or removal) (b) Date thereof 12/30/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair, Rd.

18 (a) Funeral director Lilly Beiler, Inc.
(b) Address 403 S. Wolfe St. (31)

19 DEC 28 1946 (Date rec'd by registrar) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12-26 1946, at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12 1946 to Dec 26 1946, and that I last saw h[illegible] alive on Dec 24 1946.

| Immediate cause of death | Duration |
|---|---|
| arteriosclerotic C.V. Disease. | |
| Chronic Myocarditis | Aug 12/46 |
| Due to Empyema and Fistula. | 12-2-46 |
| Due to | |
| Other Conditions None | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible] Schmidt M. D.
Address 842 S Ext Ave Date signed 12-28-46

V S 150

G46929

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. G46929

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2901 HAMPDEN AVE.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2701 HAMPDEN AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** FREDERICK HERMAN PUEPKE

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: LYDIA B. PUEPKE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 29, 1873

8. AGE: Years 72 | Months 11 | Days 27 | If less than one day hr. min.

9. Birthplace GERMANY
(Town, county, and state)

10. Usual Occupation GROCER

11. Industry or business

FATHER
12. Name ** PUEPKE
13. Birthplace GERMANY

MOTHER
14. Maiden Name **
15. Birthplace GERMANY

16 (a) Informant MR. ROBERT H. PUEPKE
(b) Address 2701 HAMPDEN AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/30/46 (month) (day) (year)
(c) Cemetery or crematory WOODLAWN CEM.
Location WOODLAWN, MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTO., MD.

DEC 28 1946 (Date rec'd by registrar)

(b) Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 26, 1946, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Dec. 26th 1946, and that I last saw him alive on Dec. 26, 1946.

Immediate cause of death: Coronary thrombosis

Due to: Cardio Vascular disease

Due to: Renal involvements

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation:

of autopsy:

Duration: Several years

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George H. Cross M. D.
Address 28 W 25th St Date signed 12-27-46

G46930 Stockley ✓ G46930

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 411 SOUTHWAY
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Albert Augustus Stockley, Jr.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| NO | NO |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| MALE | WHITE | MARRIED |

6 (b) Name of husband or wife BLANCHE C. STOCKLEY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 8, 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 1 | 18 | hr. min. |

9. Birthplace BALTIMORE, MD.
(Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business MARYLAND CASUALTY CO.

FATHER
12. Name ALBERT A. STOCKLEY
13. Birthplace ALBANY, N. Y.

MOTHER
14. Maiden Name AMELIA S. SCHILLGER
15. Birthplace BALTO., MD.

16 (a) Informant MRS. BLANCHE C. STOCKLEY
(b) Address 411 SOUTHWAY

17 (a) BURIAL (b) Date thereof 12/28/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK CEM.
Location BALTO., MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTO., MD.

19 DEC 28 1946 (b) Huntington Williams, M.D.
(Date filed by registrar) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/26 1946 at 11 25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/14 1946 to 12/26 1946 and that I last saw h. alive on 12/26 1946.

| Immediate cause of death | Duration |
|---|---|
| Pentothal | |
| Due to Coronary Occlusion. | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Coronary Occlusion
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address St Jos Hospital Date signed 12/26/46

G16931

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94B

Registered No. G46931

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 814 Somerset St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 814 Somerset St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie McArthur

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1899

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 47 | 6 | 25 | hr. min. |

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business ?

FATHER 12. Name ?

13. Birthplace N. C.

MOTHER 14. Maiden Name Eliza Buce

15. Birthplace N. C.

16 (a) Informant John W. McArthur

(b) Address 814 Somerset St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/46 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location A. A. County, Md.

18 (a) Funeral director Joseph A. Lasky, Jr.

(b) Address 1304 E. Centre St

Date received by Registrar DEC 28 1946 (b) Hampton Whitelock Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25 1946 at 9:45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/20 1946 to 12/25 1946 and that I last saw him alive on 12/24/1946.

Immediate cause of death

Due to Bronchopneumonia — Duration 15 days

Due to Angina Pectoris — Duration 7 days

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Blake M. D.

Address 1327 N. Eutaw Date signed 12-27-46

G16932

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1946

Registered No. G16932

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied—the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 319 N. Gilmor St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 319 N. Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lula Reddick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1889

8. AGE: Years 57 | Months 3 | Days — | If less than one day hr. min.

9. Birthplace Pinehurst N.C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Dan McNeil
13. Birthplace N.C.

MOTHER
14. Maiden Name Mary
15. Birthplace Pinehurst N.C.

16 (a) Informant Maude Jones
(b) Address 319 N. Gilmor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 28 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St.

19 DEC 28 1946 (Date received by Local Registrar) Huntington Williams, M.D.

V S 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 28 1946 at 7.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1946 to 12-28 1946, and that I last saw h[illegible] alive on 12-28 1946.

Immediate cause of death Cardiac - Renal — Duration 16 D

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Williams M.D.
Address 1 W Preston Date signed 12/30/46

X

G46933

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 33B

Registered No. G46933

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully reported. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 212 S. Regester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Joseph Friedel

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 9 | 10 | hr. min. |

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Louis Friedel
13. Birthplace Balto.

MOTHER
14. Maiden Name Margaret Arnold
15. Birthplace Balto.

16 (a) Informant Anna F. Crispens
(b) Address 212 S. Regester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 28 46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd.

18 (a) Funeral director Mark H. E. Duffield Sons
(b) Address 337 S. Conkling St

19 (a) DEC 28 1946 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 27 1946, at 6 40 A M

21. I certify that I took charge of the remains described above, held an Autopsy/Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Influenza & Meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. F. McNeal M.D. Medical Examiner.
Date signed Dec 27, 1946

VS 151

G46934

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G46934

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1211 Light St
(c) Hospital or institution: S. Baltimore Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 219 E Heath St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Edelman (William H. Edelman)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Anna E. Edelman 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-26-1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 9 | 2 | hr. min. |

9. Birthplace Baltimore Md (Town, county and state)
10. Usual Occupation Watchman
11. Industry or business Department Co.

FATHER 12. Name John Edelmann
13. Birthplace Md

MOTHER 14. Maiden Name Margaret Wiebel
15. Birthplace Md.

16 (a) Informant Family
(b) Address 219 E. Heath St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 12-30-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director L. H. Gaul
(b) Address 1130 E. Fayette St.

DEC 28 1946 (Date filed by Registrar) Huntington Williams Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 12-26-1946, at 10 M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 12-26 1946 to 12-26 1946 and that I last saw him alive on 12-26 1946

Immediate cause of death: Acute pulmonary edema

| Duration |
|---|
| |

Due to Coronary artery disease

Due to arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23.** Signature Richard S. Rude M. D.
Address E. Balto. Gen. Hosp. Date signed 12-27-46

VS 150

G46935

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G46935 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 Siemmer's Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Casimer Aglinskas Aglinskas

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Kathrine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | | | hr. min. |

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Retire

11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Charles Ozel
(b) Address 1927 W Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-46 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cem
Location Mt. Carmel Rd

18 (a) Funeral director Joseph Casmakes
(b) Address 60 W Washington Blvd

19 (a) DEC 28 1946 (Date received by local registrar) (b) Huntington Williams, MD (Local registrar)

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 27, 1946, at 10.10 A M

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D. Medical Examiner.
signed 12-27-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46936

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. G46936

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1900 Caroline St.
(c) Hospital or institution:
St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 720 E. 20th St. - 18
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter W. Ballman (WALTER WHITE BALLMAN)

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 213-05-9846

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Margaret Annie

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Sept 18 1981 1881

8. AGE: Years 65 | Months 3 | Days 29 | If less than one day: hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Baltimore Transit Compan

11. Industry or business

FATHER
12. Name John Ballman
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Emma ?
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Nancy Doyle
(b) Address 720 E. 20th. Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12- 30-46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) DEC 28 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1946; at 2.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from December 22 1946 to Dec 27 1946; and that I last saw him alive on Dec 27 1946.

| Immediate cause of death | Duration |
|---|---|
| Cardio-Respiratory Failure | |
| Due to Uraemia and | |
| Due to Cerebral Vascular Accident | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None permitted

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 14 for. Hoyd Date signed 12/27/46

G46937

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 124 B

Registered No. G46937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1816 N. Chester Street
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1816 N. Chester Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** KATHERINE ELIZABETH GLOCK

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widow |

6 (b) Name of husband or wife Adam Glock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 10 | 4 | hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Aufret
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Thomas Cunningham - daughter
(b) Address 1816 N. Chester Street

17 (a) Burial (b) Date thereof 12-30-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) DEC 28 1946 (b) Huntington Williams M.D.
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 26 1946 at 10.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to Dec. 26 1946 and that I last saw h[illegible] alive on Dec. 23 1946

| Immediate cause of death | Duration |
|---|---|
| Decompensated Heart | about 6 years |
| Due to Hypertension & Sclerosis of H. Muscle | |
| Due to | |
| Other Conditions Sclerosis liver & kidneys. | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Karl Trumpf M. D.
Address 1623 E. N. Avenue Date signed 12-27-46

V S 150

G46938

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 106c

Registered No. G46938

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood + Greene Sts
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Woodlawn
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rolling + Airport Rds
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Marie Lee Rose

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 3 | 4 | hr. min. |

9. Birthplace Baltimore Co. Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

| | |
|---|---|
| FATHER | 12. Name Lee A. Rose |
| | 13. Birthplace Cass West Virginia |
| MOTHER | 14. Maiden Name Genevieve Lovet |
| | 15. Birthplace Cloudville France |

16 (a) Informant Lee A. Rose
(b) Address Woodlawn #7 Md.

17 (a) Burial (b) Date thereof Dec. 29, 1946.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Rockland Md.

18 (a) Funeral director Easton Lowe
(b) Address Ellicott City, Md.

19 DEC 28 1946 Registrar Williamsville, Md.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-25 1946 to 12-27 1946, and that I last saw h.s.x. alive on 12-27 1946

Immediate cause of death Respiratory failure
Due to Partial atelectasis
Due to Foreign tracheitis
Other Conditions Pneumonia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy, Atelectasis

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. B. Hurley, M.D.
Address Keen Hosp. Date signed 12-28-46

G46939

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

12B

G46939
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 336 S. Payson Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 336 S. Payson Street
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

**3 (a) FULL NAME** Elizabeth Barthel

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: William Barthel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1875

8. AGE: Years 71 | Months 5 | Days 29 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Wagener
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Faal
15. Birthplace Germany

16 (a) Informant Lena L. Falkenski
(b) Address 336 S. Payson St.

17 (a) Burial (b) Date thereof 12-31-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director Geo. L. Schwab
(b) Address 2101 Frederick Ave.

19 (a) Date registered DEC 29 1946 (b) Registrar Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** December 28, 1946, at 2:15 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from 1926, to Dec 29 1946, and that I last saw h[illegible] alive on Dec 26 1946

| Immediate cause of death | Duration |
|---|---|
| Myocarditis with decompensation | |
| General anasarca | 10 days |
| Due to Chr. pulmonary tuberculosis | |
| Due to | 15 years |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation ✓
Major findings of operation: ✓
of autopsy: ✓

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Federic U. Beutler M. D.
Address 723 Mercer St Balto Md. Date signed 12-28-46

X

G46940

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1937

G46940 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dott
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 West Lombard (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James William French

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| m | w | divorced |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | | | hr. min. |

9. Birthplace Middlesex Co. Va (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name William J. French
13. Birthplace Va.

MOTHER
14. Maiden Name Vernah Revere
15. Birthplace Va.

16 (a) Informant Miss Sue Hall
(b) Address Middlesex Co Va

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/28/46 (month) (day) (year)
(c) Cemetery or crematory Harmony Grove
Location Middlesex Co Va

18 (a) Funeral director Wm. Goodwin
(b) Address 1217 St. Paul St.

19 (a) Huntington Williams, Md. (Date received by Registrar) Registrar

DEC 29 1946

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27/46 19..., at 4:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 12/28/46

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46941

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X V 170c

G46941
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dor
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Anne Arundel
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. Severna Park
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John FORD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 62 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace: Keysville, Virginia
(Town, county, and state)

10. Usual Occupation: Farmer

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Unknown

16 (a) Informant: Augustine Palmer
(b) Address: 608 Cornell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-46 (month) (day) (year)
(c) Cemetery or crematory: Earleigh Heights
Location: A.A. Co. Md.

18 (a) Funeral director: James A. Hayes
(b) Address: 942 Russell St

19 (a) (Date rec'd by registrar) (b) Hunter from Williams Registrar

DEC 29 1946

AS-151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 25th 1946, at 1 55 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Intracranial hemorrhage
Due to: Lacerations and abrasions of scalp

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/25/46 at 1 55 A. M.
(b) Where did injury occur? Ritchie Highway & Earley Lights Service
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Pedestrian Struck By Auto.

23. Signature: George L. Merrell M.D.
Medical Examiner.
Date signed 12/26/46

X

G46942 ✓ G46942

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 58c

Registered No.

write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3607-9th St. Brooklyn, Md.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3607-9th St. Brooklyn (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Doris MAY Sellers ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name of husband ~~or wife~~ Charles E. Sellers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7th 1924

8. AGE: Years 22 | Months 7 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation File Clerk

11. Industry or business Social Security Board

FATHER
12. Name Charles H. Weir
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Clara Labatue
15. Birthplace Balto. Md.

16 (a) Informant Chas. E. Sellers
(b) Address 3607 Ninth St. - Brooklyn

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 12/31/46 (month) (day) (year)
(c) Cemetery or ~~crematory~~ U. S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) DEC 29 1946 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 28, 1946, at 9.30 A. M.

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rheumat. C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. L. Lubinski M.D. Medical Examiner.

Date signed 12-28-46

X

G46943 ✓ G46943

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 51 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1618 Chilton st
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 Chilton
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Michael Mele

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~ |
|---|---|---|
| Male | White | Widowed |

6 (b). Name of ~~husband or~~ wife Josephine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9th 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 6 | 18 | hr. min. |

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business Isaac Hamburgers

FATHER
12. Name Alessio Mele
13. Birthplace Italy

MOTHER
14. Maiden Name Frances (Unknown)
15. Birthplace Italy

16 (a) Informant Mrs. Amelia Collins
(b) Address 1618 Chilton st.

17 (a) Burial (b) Date thereof 12/30/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st

19 1946 (b)
(Rec'd by registrar) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 27th 1946, at 2.44 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1/46 19 to 12/27/46, and that I last saw h~~im~~ alive on 12/27/46

| Immediate cause of death | Duration |
|---|---|
| Myocardial Degen | 1 mo |
| Due to Carcinoma Prostate | 4 yrs |
| Due to | |
| Other Conditions none | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Hannigan M. D.
Address 1710 E 33rd Date signed 12/28/46

G46944

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G46944 / 92 C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 31st & Wyman Park Drive
(c) Hospital or institution: U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County –
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 327 Scott St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** BAKER, HUBERT LEE

3 (b) If veteran, name war –
3 (c) Social Security Account No. –

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | single |

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/22/26

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 20 | 1 | 5 6 | 12 hr. min. |

9. Birthplace Greenville, N.C. (Town, county, and state)
10. Usual Occupation merchant seaman
11. Industry or business

FATHER
12. Name James S. Baker
13. Birthplace N.C.

MOTHER
14. Maiden Name Mattie Moore
15. Birthplace N.C.

16 (a) Informant self
(b) Address

17 (a) Shipped. (Burial, cremation, or removal) (b) Date thereof 12/29/46 (month) (day) (year)
(c) Cemetery or crematory Greenville N.C.
Location Same.

18 (a) Funeral director E. J. Peters Stone
(b) Address 1601 Light St

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 29 1946 Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 12/28/46 19 , at 12 noon

**21.** I certify that death occurred on the date above stated; that I attended deceased from 12/23/46 19 to 12/28/46 19 , and that I last saw him alive on 12/28/46 19 .

| Immediate cause of death | Duration |
|---|---|
| Endocarditis, Rheumatic, Chronic, with Aortic Stenosis and Congestive Heart Failure | unknown |
| Due to Pulmonary Infarction, multiple | 1-2 weeks |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: confirmatory

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23. Signature** Paul E. Walker – M. D.
Address U. S. Marine Hosp. Date signed 12/29/46

G46945

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46945 Registered No. 122 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave.
(c) Hospital or institution: The Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County —
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 N. Decker Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Reynolds, Mrs. Philomena

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-01-5796

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife Reynolds, Mr. Arthur
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 17 1913

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 33 | 0 | 12 | ..... hr. ..... min. |

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business Housework

FATHER
12. Name Ponce, Thomas
13. Birthplace New York

MOTHER
14. Maiden Name Meeks, Christine
15. Birthplace Ohio

16 (a) Informant Relative
(b) Address 1505 N. Decker Ave. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 31st 1946 (month) (day) (year)
(c) Cemetery Oak Lawn
Location 7225 Eastern Ave Baltimore Md.

18 (a) Funeral director Frank Della Vale
(b) Address 52 N. Morley St.

19 (a) Date received by registrar DEC 29 1946 (b) Registrar Huntington for Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Dec 1946, at 1:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 Dec 1946, to 28 Dec 1946, and that I last saw h-er alive on 28 Dec 1946

| Immediate cause of death | Duration |
|---|---|
| (a) Cardiac failure | |
| Due to (b) Uremia | |
| Due to (c) ? Intestinal Obstruction | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 20 Dec 1946
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nicholas J. Stollerman M. D.
Address The Church Home & Hosp. Date signed 28 Dec 46

X

G46946

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G46946
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1275 Battery Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 4
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1275 Battery Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas M. O'Byrne

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife [redacted]

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30-1881

8. AGE: Years 65 | Months 6 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business none

FATHER
12. Name Patrick O'Byrne
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridgt Burke
15. Birthplace Baltimore Md.

16 (a) Informant William J. O'Byrne
(b) Address 1275 Battery Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flynn & Flanagan
(b) Address 1426 Light St. Baltimore, Md.

19 DEC 29 1946 (Date filed by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26/46 19 at 10:15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/ 19 45 to 12/26 19 46 and that I last saw h[illegible] alive on 12/26 19 46

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 1 day |
| Due to Arteriosclerosis | |
| Due to Myocarditis C | 1 yr |
| Other Conditions Heart murmur | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isaac Mullen M. D.
Address 1 W Chase St (Physician)

VS 150

Williams, Md

X 12/27/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46947 / 107

Registered No. G46947

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 704 N Collington ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mos

**2. USUAL RESIDENCE OF DECEASED:**
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 704 N Collington ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter S Melee
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. widower
6 (b) Name of husband or wife Weltha J Melee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 6-1866

8. AGE: Years 80 | Months — | Days 23 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Grocer
11. Industry or business

FATHER 12. Name Aquilla Melee
13. Birthplace Unknown

MOTHER 14. Maiden Name Anna M Lockard
15. Birthplace Unknown

16 (a) Informant Stanley Melee
(b) Address 4901 Green Spring ave Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-46 (month) (day) (year)
(c) Cemetery or crematory St Paul's
Location Baltimore Md

18 (a) Funeral director Edw C Tipton
(b) Address Hampstead Md

DEC 29 1946 (Date rec'd by Registrar) (b) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/29/46 19 , at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1946, to Dec 29 1946, and that I last saw h[illegible] alive on Dec 28, 1946

Immediate cause of death — Duration

Broncho Pneumonia — 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Joseph Pokorny M. D.
Address 2200 E Madison St Date signed 12/29/46

G46948

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46B

G46948 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2108 Mosby Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2108 Mosby Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Thomas Martin

3 (b) If veteran, name war --

3 (c) Social Security Account No. 212-12-6553

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary G. Martin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1871

8. AGE: Years 75 | Months 11 | Days 6 | If less than one day: hr. min.

9. Birthplace Baltimore Co., Md.
(Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business American Sugar Refinery

FATHER
12. Name Patrick Martin
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary E. Suddrey
15. Birthplace Baltimore Co., Md.

16 (a) Informant Mrs. Mary G. Martin
(b) Address 2108 Mosby Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) 12-30-1946 (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION** 10.04

20. DATE OF DEATH December 27, 1946, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1946 to Dec 27 1946, and that I last saw h alive on Dec 26 1946

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 3 days |
| Due to Arterio Sclerosis | |
| Due to | |
| Other Conditions Contusion of Stomach & Hemorrhage (Include pregnancy within 3 months of death) | 3 days |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. C. Summers M. D.
Address 4 S [illegible] St. Date signed Dec 29

Registrar Huntington Williams, M.D.

VS 150

G46949

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G46949 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 813 Mt. Holly St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 813 Mt. Holly St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Frank Paul Kratz, Jr.

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 212-03-9007

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Frances Kratz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26, 1901

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 45 | 7 | 1 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Wallace & Gale

FATHER
12. Name Frank P. Kratz
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Wilhelmina Meyer
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Frances Kratz
(b) Address 813 Mt. Holly St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) 12-30-1946 (b) Registered by registrar Washington Williams, Registrar

VS 150

**MEDICAL CERTIFICATION** 10.00

20. DATE OF DEATH Dec. 27, 1946, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1946 to Dec 27 1946. and that I last saw him alive on Dec 27 1946.

| Immediate cause of death | Duration |
|---|---|
| Edema Lungs. | |
| Due to Myocardial insufficiency | |
| Due to Chronic hypertensive cardiovascular disease. | 10 yrs + |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter E. Thompson M. D.
Address 1013 Poplar Grove. Date signed Dec 28 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1701C

G46950 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2412 Jefferson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Richard H. Tearle

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2-1938

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 8 | 8 | 22 | hr. min. |

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation School Boy

11. Industry or business

FATHER
12. Name Joseph G. Tearle
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elsie Marie Noakes
15. Birthplace Balto. Md.

16 (a) Informant Elizabeth Anderson
(b) Address 3403 Richmond Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 30/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location North Ave. & Gay St.

18. (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.

19 Dec 30 1946 (b) Registrar
(Date received by registrar)

Huntington Williams, M.D. Registrar

VS 181

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** December 27, 19 46, at 4:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed head with complete avulsion of brain tissue

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/27/46 at 3:50 P.M.
(b) Where did injury occur? 500 Blk N. Port St.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury While playing in street, struck by truck

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed 12-28-46

X

G46951

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

137a G46951 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mon.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Anne Arundel
(c) City or town Glen Burnie (Rural)
(If outside city or town limits, write RURAL and give town)
(d) Street No. Marley Neck Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Robert H. Williams

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| ? | ? |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Katherine Williams (Mrs. Lockington) 6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Mar. 11, 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 9 | 17 | hr. min. |

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Barber
11. Industry or business Trade & Helper (Boat)

FATHER
12. Name Benjamin Williams
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Burton
15. Birthplace Md.

16 (a) Informant Mrs. Katherine Williams (wife)
(b) Address Marley Pky. & Balto. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31 1946 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto. Md.

18 (a) Funeral director A. W. Brown & Sons
(b) Address 1005 E. Baltimore St.

19 (a) Date received (month) (day) (year) (b) Name of Registrar

DEC 30 1946

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-28 1946, at 2:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-19 1946 to 12-28 1946 and that I last saw him alive on 12-27 1946

Immediate cause of death Pneumonia, Hypostatic — Duration 4 days

Due to Paralysis from Thromb. of Rt. Mid-Cerebr. Art. — Duration 3½ weeks

Due to Perineal Prostatectomy for Benign Prostatic Hypty. — Duration 2½ weeks

Other Conditions Uremia due to Urinary Retension — Duration 4 mon

(Include pregnancy within 3 months of death)

Date of operation 12-16-46

Major findings of operation: B.P.H.

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William D Dailey, Jr M.D.
Address Mercy Hosp. Date signed 1-2-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46952

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

8313

G46952 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 417 Fulpeds St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 417 Fulpeds St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Geraldine Bailey Hipkins.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced widow

6 (b) Name of husband or wife Wm. Hipkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1870

8. AGE: Years 76 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Mabel Bailey
(b) Address 1205 W 40th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 30/46 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Taylor Ave.

18 (a) Funeral director Edmondson & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) (Date rec'd by Local Reg.) DEC 30 1946 (b) Registrar Huntington Williams, M.D.

VS-150

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 27, 1946, at 3 20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19th 1946 to Dec 27 1946 and that I last saw h. alive on Dec 26th 1946

| Immediate cause of death | Duration |
|---|---|
| Cerebral Thrombosis | 11 days |
| Due to Generalized Arterial Sclerosis | 10 yrs. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Williams M.D.
Address 617 W. 40th St Date signed 12/29/46

X

G46953

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1610

G46953 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2506 Calverton Hgts Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Parlett (GEORGE J. PARLETT)

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/27/46

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name George J. Parlett
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth C. Callahan
15. Birthplace Va

16 (a) Informant Julia Traylor
(b) Address 1583 W. Lafayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 30 46 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Rt 40 & B. M. Walters

18 (a) Funeral director Pratt Funeral Home
(b) Address Pratt & Fulton Sts

19 (a) (Date rec'd by registrar) (b) Wilmington Del

DEC 30 1946 Huntington Williamsport Md

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/27 1946, at 7:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27 1946, to 12/27 1946, and that I last saw h[illegible] alive on 12/26 1946

Immediate cause of death: Bilateral atelectasis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard Greene M. D.
Address [illegible] Date signed 12/27/46

X

G46954

G46954

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH X 160a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Oella, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 50 Oella Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Judith Riddle

3 (b) If veteran, name war

3 (c) Social Security Account No. None

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1946.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 2/12 | hr. min. |

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business None

FATHER 12. Name Frank R. Riddle Jr.

13. Birthplace Woodstock, Md.

MOTHER 14. Maiden Name Frances Whitlock

15. Birthplace Tope, Va.

16 (a) Informant Frank R. Riddle Jr.

(b) Address Oella, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 | 31 | 46. (month) (day) (year)

(c) Cemetery or crematory Good Shepherd Cemetery

Location Ellicott City, Md.

18 (a) Funeral director Easton & Sons

(b) Address Ellicott City, Md.

19 (a) DEC 30 1946 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29 1946 at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27 1946 to 12-29 1946 and that I last saw h[illegible] alive on 12-24 1946.

| Immediate cause of death | Duration |
|---|---|
| Diffuse fasciotomitis | |
| Due to Erysipelas | |
| Due to | |
| Other Conditions Bed hemorrhage? M.R.I. (Include pregnancy within 3 months of death) | |

Date of operation

Major findings of operation

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. B. Harley, M.D.

Address Univ. Hosp. Date signed 12-29-46

VS 150

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-86534 G46955

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

12

Registered No. G46955

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs- 10mo-9days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County 26-12
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
No Home
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Robert Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Col. | Wid. |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15th- (87?

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 87 ? | ? | 12 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wilbert Bell (D
13. Birthplace Maryland

MOTHER
14. Maiden Name Harriett Marshall or Marshell
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Dec 31, 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Bur. Un. A. Stallings
(b) Address 1631 Druid Hill Ave

19 (a) (b)
(Registrar's signature)

Dec 30 1946

V5 750

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 27 1946, at 12.05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-18- 1944, to 12-27 1946, and that I last saw him alive on 12-27 1946.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Tuberculosis | yrs |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Surg.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.
Address Balt. City Hosp. Date signed 12/27/46

X

G46956

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

166

Registered No. G46956

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 Clendenin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Theodore Wilkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) ~~Single~~, Married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1932

8. AGE: Years 14 | Months ~ | Days ~~ | If less than one day hr. min.

9. Birthplace Victoria, Va
(Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name William Wilkins
13. Birthplace Victoria, Va

MOTHER
14. Maiden Name Georgia Bridgeforth
15. Birthplace Victoria, Va

16 (a) Informant Solomon Bridgeforth
(b) Address Victoria

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 31, 1946 (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Victoria, Va

18 (a) Funeral director Jas. H. Hallam
(b) Address 1631 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 30 1946 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 27, 1946 at 12 p M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wounds of head & chest

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-27-46 10 a. M.
(b) Where did injury occur? 1108 Clendenin St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Firearms - automatic

23. Signature Howard J. Anderson M.D.
Medical Examiner.
Date signed 12-27-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46957

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

166

Registered No. G46957

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital D.O.a.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 Clendenin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Georgia Wilkins

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Color or race Colored — 5. Sex Female — 6 (a) Single, married, widowed or divorced. Married

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1915

8. AGE: Years 31 | Months 10 | Days 8 | If less than one day hr. min.

9. Birthplace Victoria, Va (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Solomon Bridgforth

13. Birthplace Victoria, Va

MOTHER 14. Maiden Name Mattie Canty

15. Birthplace Victoria, Va

16 (a) Informant Solomon Bridgforth

(b) Address Victoria, Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31, 1946 (month) (day) (year)

(c) Cemetery or crematory Family Lot

Location Victoria, Va

18 (a) Funeral director Jno. Geo. H. Stallard

(b) Address 1631 Druid Hill Ave

19 (a) DEC 30 1946 Registrar — Courtney Williams, M.D.

VS 151

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec. 27, 1946, at 12 p M

**21.** I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to (his) death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wounds of head, neck & chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 12-27-46 10 a. M.

(b) Where did injury occur? 1108 Clendenin St.

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Firearms - automatic

(e) Signature Howard J. Mallonee M.D. Medical Examiner.

Date signed 12-27-46

G46958

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

M4a

G46958 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 324 East 22nd Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 324 East 22nd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** HARRY WALMSLEY TIPTON

3 (b) If veteran, name war ----

3 (c) Social Security Account No. 220-24-6222

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1928

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 18 | | | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation ----

11. Industry or business

FATHER
12. Name Lee Wylie Tipton
13. Birthplace Balto.,Md.

MOTHER
14. Maiden Name Harriet Walmsley
15. Birthplace Balto., Md.

16 (a) Informant Mr. L.W.Tipton
(b) Address 324 East 22nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/46 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location City

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT & 22nd ST.

19 (a) (Date rec'd by registrar) (b) Williams, M.D. Registrar

VS 1 DEC 30 1946

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 28th 1946 at 8:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to Dec. 28 1946 and that I last saw him alive on Dec. 27 1946.

Immediate cause of death Chronic Lymphoid Leukemia — Duration 10 Mos.
Due to
Due to
Other Conditions None.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

William G. Tipton M. D.
Address 2824 St. Paul St. Date signed 12-28-46
Baltimore, Md. X

G46959

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46959

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 414 Stricker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2-7yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town write RURAL and give town)
(d) Street No. 414 Stricker St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

**3 (a) FULL NAME** Gloria Maitland

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1924

8. AGE: Years 22 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Nathaniel Maitland

13. Birthplace N. C.

MOTHER 14. Maiden Name Mattie Johnson

15. Birthplace Batteburg Md.

16 (a) Informant Thelma Black Well

(b) Address 414 N. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/46 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Location Baltimore Co.

18 (a) Funeral director Metropolitan Funeral Home

(b) Address 927 N. Mount St.

19 (a) ... (b) ... (Date rec'd by registrar) Registrar

VS 1 DEC 30 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-27-1946, at 9:45 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 12/20 1946 to 12/27 1946, and that I last saw her alive on 12/26 1946.

| Immediate cause of death | Duration |
|---|---|
| Intercerebral Osteomyelitis | 1 year |
| Intercerebral Meningitis | 2 days |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature ... M. D.
Address ...

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46960

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46E

Registered No. G46960

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3606 Old Frederick Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3606 Old Frederick Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** HELEN LOUISE HOLMES

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | single |

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1902

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 44 | 2 | 6 | hr. min. |

9. Birthplace BALTIMORE
(Town, county, and state)
10. Usual Occupation NURSE
11. Industry or business INSTRUCTIVE VISITING NURSE ASSO.

FATHER
12. Name CLARENCE E. HOLMES
13. Birthplace BALTO., MD.

MOTHER
14. Maiden Name MARY WEBER
15. Birthplace BALTIMORE

16 (a) Informant MRS. ISABELLE FEHN
(b) Address 3606 OLD FREDERICK RD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/30/46 (month) (day) (year)
(c) Cemetery or crematory LOUDON PK. CEM.
Location BALTO., MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTO., MD.

19 (a) (Date rec'd by registrar) (b) [illegible] Address 4104 Liberty Heights Ave

VS DEC 30 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 27, 1946, at 7:40 a M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1946, to Dec 27 1946, and that I last saw h. alive on Dec 26 19 46.

| Immediate cause of death | Duration |
|---|---|
| General metastasis | ? |
| Due to Carcinoma of sigmoid | 2 yr.? |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: ✓

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank Lemmon M. D.
Date signed 12/28/46

G46961

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G46961

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4510 WHITE OAK AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4510 WHITE OAK AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ADOLPH R. CALOYRO

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| MALE | WHITE | MARRIED |

6 (b) Name of husband or wife: ANNA E. CALOYRO
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 4, 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 11 | 23 | hr. min. |

9. Birthplace ITALY (Town, county, and state)
10. Usual Occupation REAL ESTATE
11. Industry or business SELF

FATHER
12. Name ISADORE CALOYRO
13. Birthplace ITALY

MOTHER
14. Maiden Name CLEMENTINE
15. Birthplace ITALY

16 (a) Informant MRS. ANNA E. CALOYRO
(b) Address 4510 WHITE OAK AVE.

17 (a) BURIAL (b) Date thereof 12/30/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Union Bridge, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTO., MD.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 DEC 30 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 27, 1946, at 8:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944 to Dec 27 1946 and that I last saw h[illegible]live on Dec 27 1946

Immediate cause of death: Coronary Thrombosis — Duration 6 hr
Due to: Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard A Caloyro M.D.
Address 511 Cambridge Date signed 12-28-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46962

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G46962 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3603 Belle ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Tokar

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Sera

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-14-1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 9 | 15 | hr. min. |

9. Birthplace Russia (Town, county, and state or foreign country)

10. Usual Occupation Ladies Tailor

11. Industry or business

FATHER 12. Name Solomon

13. Birthplace Russia

MOTHER 14. Maiden Name Libby

15. Birthplace Russia

16 (a) Informant Sera Tokar

(b) Address 3603 Belle ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-46 (month) (day) (year)

(c) Cemetery or crematory Beth Tfiloh

Location Lowndes Mill Road

18 (a) Funeral director Jack Lewis Inc

(b) Address 1419 E Balto St

19 (a) (Date received) DEC 30 1946 (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29- 1946, at 8:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-26 1946 to 12-29 1946 and that I last saw him alive on 12-27-1946.

Immediate cause of death Cardiac failure — Duration

Due to Myocardial disease — Coronary sclerosis

Due to Arteriosclerotic heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bertha Rader M. D.

Address Sinai Hospital Date signed 12-29-46

VS 150

G46963

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 49a

G46963 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Belvedere Ave
(c) Hospital or institution: Aged Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Freemont & Belvedere Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** IDA ECHIKSON

3 (b) If veteran, name war —

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | W |

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | | | hr. min. |

9. Birthplace Bussey. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Louis
13. Birthplace Russia

MOTHER
14. Maiden Name French
15. Birthplace Russia

16 (a) Informant Aged Home
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Phila Pk & Hamilton Ave

18 (a) Funeral director Frank Lewis Sons
(b) Address E Baltimore St

19 (a) (Date rec'd by registrar) DEC 30 1946 (b) Huntingdon Pa Williamsport Md

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 12-29 1946, at 1:32 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from October 1941, to 12-29 1946, and that I last saw her alive on 12-29 1946.

Immediate cause of death Carcinoma of ovary — Duration

Due to

Due to

Other Conditions Cerebr arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Nagel M. D.
Address Leesdale Home Date signed 12-29-46

X

VS 190

G46964 BALTIMORE CITY HEALTH DEPARTMENT G46964
CERTIFICATE OF DEATH 467 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Altamont Hotel (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Berta Straus
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1869
8. AGE: Years 77 Months Days If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Herman
13. Birthplace Germany
MOTHER 14. Maiden Name Hannah
15. Birthplace Germany
16 (a) Informant Max Sulz
(b) Address Sylvest Apts
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-46 (month) (day) (year)
(c) Cemetery or crematory Balto Hebrew
Location Belair Road
18 (a) Funeral director Jack Lewis Inc
(b) Address 609 E Balto St
19 (a) (Date rec'd by Local Reg.) DEC 30 1946 Registrar Washington Williams

MEDICAL CERTIFICATION
20. DATE OF DEATH 12-28- 1946 at 5A M
21. I certify that death occurred on the date above stated; that I attended deceased from 11-25 1946 to 12-25 1946 and that I last saw h alive on 12-25- 1946.

| | Duration |
|---|---|
| Immediate cause of death Circulatory failure | |
| Due to Carcinomatosis | |
| Due to Rectal carcinoma | |
| Other Conditions Cachexia, gan gangrene ? Ischio-rectal abscess (Include pregnancy within 3 months of death) | |
| Date of operation 11-29-46 | |
| Major findings of operation: Ischio-rectal abscess & gangrene + perforation of autopsy: | |

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Bertha Rader M. D.
Address Sinai Hosp Date signed 12-28-46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

506840
G46965

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X55E

G46965 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Mo (b) County
(c) City or town Kansas City (If outside city or town limits, write RURAL and give town)
(d) Street No. 819 E. 11th St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Dr John R. Hughes

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ida Hughes
6 (c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.) May 5, 1893

8. AGE: Years 53 | Months 7 | Days 24 | If less than one day: hrs. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER
12. Name Dr. J. H. Hughes
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth Tarp
15. Birthplace Ireland

16 (a) Informant Mrs. Ida Hughes
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/47 (month) (day) (year)
(c) Cemetery or crematory
Location Kansas City, Mo.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Bway Place

19 (a) DEC 30 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 24 1946 to Dec 29 1946, and that I last saw h.. alive on Dec 29 1946.

| Immediate cause of death | Duration |
|---|---|
| Widespread carcinoma | |
| primary source unknown | 5 yrs |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L.S. Tanner
Address Johns Hopkins Hospital Date signed 12/29/46
Balto.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46966

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 309

G46966. Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3029 Brighton St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Matthews
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 18, 1874
8. AGE Years: (72) Months: 11 Days: 21 If less than one day hr. min.
9. Birthplace Unknown Balto Co. Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown Aquila Matthews
13. Birthplace Md

MOTHER
14. Maiden Name Unknown Mary S. Dunn
15. Birthplace Md

16 (a) Informant Aquilla J. Matthews
(b) Address 609 E. 33rd St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 30/46 (month) (day) (year)
(c) Cemetery or crematory Friends Burying Ground
Location Sparks Md
18 (a) Funeral director John O. Mitchell & Sons
(b) Address 400 Eutaw Place
19 DEC 30 1946 (b) Huntington Williams Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1946, at 7.05 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 12/4 1946, to 12/27 1946, and that I last saw h.LIVE alive on 12/27 1946

| Immediate cause of death | Duration |
|---|---|
| Terminal Bronchopneumonia | 1 day |
| Due to Multiple Small Cerebral Thrombi | 8 month |
| Due to Cerebral Arteriosclerosis | 2 yrs |
| Other Conditions Syphilis (Include pregnancy within 3 months of death) | |
| Date of operation | |
| Major findings of operation: | |
| of autopsy: Cerebral Thrombi | |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Edward H. Southwick M.D.
Address Franklin Sq Hosp Date signed 12/27/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46967

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G46967

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1923 Longwood St.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1923 Longwood St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Alice K. Godwin

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| female | white | married |

6 (b) Name of husband or wife: Daniel H. Godwin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 5 | 28 | hr. min. |

9. Birthplace New York (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name George Vicary
13. Birthplace England

MOTHER
14. Maiden Name Rose Cornish
15. Birthplace England

16 (a) Informant Daniel H. Godwin
(b) Address 1923 Longwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/46 (month) (day) (year)
(c) Cemetery or crematory Spesutia
Location Perryman, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by Registrar) DEC 30 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 28, 1946, at 3 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1939 to Dec 28 1946, and that I last saw her alive on Dec 28 1946

| Immediate cause of death | Duration |
|---|---|
| Coronary occlusion | 2 hrs |
| Due to Arteriosclerosis + Hypertension | ? |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hattie Stuart M. D.
Address 2220 Garrison Ave. Date signed

VS 150

G46968

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

G46968 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2660 Edmondson ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Ind (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2660 Edmondson ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anna T. Iglehart

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-4212

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: W. W. Iglehart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23—

8. AGE: Years: Unknown | Months: about | Days: 6 | If less than one day: hr. min. | 68 yrs

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Retired Saleslady.

11. Industry or business

FATHER
12. Name George H. Imerson.
13. Birthplace Unknown.

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Oscar J. Pharle
(b) Address 803. Walnut ave 29.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 31-1946 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Baltimore

18 (a) Funeral director Mamie Cook Syfer
(b) Address 1900 W North Ave.
(c) Date rec'd by Registrar DEC 30 1946 Registrar Hamilton for Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 28 1946, at 12-30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1938 to Dec 28 1946, and that I last saw h alive on Dec 27 1946.

Immediate cause of death: Cancer of right breast — Duration: 6 yrs.

Due to

Due to

Other Conditions: Essential Hypertension, Hypertensive Heart Disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Eberhart

Address 2302 Eutaw Pl Date signed 12-30-46 M.

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46969

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

107

G46969

Registered No. 24747

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 544 Burgundy H.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 544 Burgundy H. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Thomas Henry Innes

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C. | M. |

6 (b) Name of husband or wife Laura Innes
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) June 30, 1892

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 | 6 | 30 | – hr. – min. |

9. Birthplace Patapsco Hill Md.
(Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name William Innes.
13. Birthplace Dayonville Md.

MOTHER
14. Maiden Name Emilia Matthews
15. Birthplace Annapolis Md.

16 (a) Informant Laura Innes
(b) Address 544 Burgundy St.

17 (a) Burial (b) Date thereof Jan 2-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location

18 (a) Funeral director James A Dayon
(b) Address 1422 W. Hazel St

19 (a) DEC 30 1946 (b) Huntington Williams, M.D.
Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 29 1946, at 2:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 27 1946, to Dec. 29 1946, and that I last saw him alive on Dec. 29 1946.

| Immediate cause of death | Duration |
|---|---|
| Bronchio Pneumonia | 1wk. |
| Due to Bronchiectasis | 3 |
| Due to | |
| Other Conditions Arthritis | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ronald B. Lyle M. D.
Address 501 Cherry Hill Rd. Date signed 12/30/46

G46970
506644

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH X46B

G46970
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County 53-00
(c) City or town Baltimore Co., Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 400 Railroad Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Maggie Lee

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Geo. R. Lee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 23. 1870

8. AGE: Years 76 | Months 9 | Days 4 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Jacob Smith
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Barton
15. Birthplace Maryland

16 (a) Informant Mildred Taylor
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Long Green, Md.

18 (a) Funeral director William J. Chatman
(b) Address 1701 McCulloh St.

DEC 30 1946 (Registrar) Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1946 at 9:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 19 1946 to Dec. 27 1946, and that I last saw her alive on Dec 27 1946

Immediate cause of death: Post-operative cerebral accident — Duration:

Due to: Arteriosclerosis and post-operative shock

Due to: Extensive carcinoma of stomach — Duration: 1 yr.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Dec 24 1946

Major findings of operation: Ca of stomach with metastasis to regional nodes

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Paul Huggins M.D.

Address Johns Hopkins Hospital Date signed 27 Dec 46

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G16971 / 46 B

Registration No. G16971

G16971

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2015 Ellsworth St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 Ellsworth St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Walter E. Stevens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha M. Stevens

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) April 22 1875

8. AGE: Years 71 | Months 8 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Delaware (Town, county, and state)

10. Usual Occupation

11. Industry or business City of Balto.

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Bertha M. Stevens

(b) Address 2015 Ellsworth St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-30-46 (month) (day) (year)

(c) Cemetery or crematory Balto. Cem.

Location North Ave. & Miller Line

18 (a) Funeral director Jos. E. Oliver

(b) Address 2435 E. Oliver St

19 (a) (Date rec'd by registrar) (b)

Dec 30

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 12-26-1946 at M

**21.** I certify that death occurred on the date above stated; that I attended deceased from November 1946 to Dec. 26 1946 and that I last saw him alive on 12-26 1946

Immediate cause of death Coronary Thrombosis

Due to Duration: Months

Due to

Other Conditions Circulatory failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Kane Thompson M. D.

Address 1623 E. Monument Date signed 12-28-46

G46972

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G46972 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2844 Harlem Ave.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2844 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Martin List

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| NO | 218-01-8337 |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Gertrude List
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 3 | 3 | hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business ?

FATHER
12. Name Frederick List
13. Birthplace Germany

MOTHER
14. Maiden Name M. Hanken
15. Birthplace Germany

16 (a) Informant Gertrude List
(b) Address 2844 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/46 (month) (day) (year)
(c) Cemetery or crematory Western Cem[illegible]
Location Woodlawn, Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

DEC 30 1946 (Date rec'd by registrar) [illegible] for Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 28 1946, at 2:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/12/46 to 12/28 1946, and that I last saw h[illegible] alive on 12/2 1946

Immediate cause of death Coronary Thrombosis — Duration 8 hours

Due to

Due to

Other Conditions Arteriosclerosis Cardiac Vascular Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. R. Ellison M. D.
Address 107 E West Date signed 12/28/46

VS 150

G46973

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46973 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 Carswell St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Catherine Thrasher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 41 | | | hr. min. |

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Sales Lady

11. Industry or business Mays Co.

FATHER
12. Name Wm V. McFeeleans
13. Birthplace Md

MOTHER
14. Maiden Name Alverta Stockstein
15. Birthplace Md

16 (a) Informant Mr. McFeeleans
(b) Address 1711 Warley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 30 1946 (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location E North Ave Ext

18 (a) Funeral director Leo S. Leach
(b) Address 1701-03 N. Patterson Park ave

DEC 30 1946 (b) Huntington Williams M.D.

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec. 27, 1946, at 1.05 a M

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Incised wounds of neck; Stab wounds of chest and hands

Due to: Multiple bruises, Fractured left ribs

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was ~~suspected~~ ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-27-46 approx. 12.30a. M.
(b) Where did injury occur? 1608 Carswell St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Sharp Instrument

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 12-27-46

VS 151

G46974

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1/30

G46974 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Laynes + Cleveland
(c) Hospital or institution: St. Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2323 E. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Wolff

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20th 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 8 | 5 | hr. min. |

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business W.S.B.+S.

FATHER
12. Name David W. Wolff
13. Birthplace Md

MOTHER
14. Maiden Name Rebecca Elliott
15. Birthplace Md

16 (a) Informant Mrs Mary Mayo Learis
(b) Address 1911 Darley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 1 1947 (Month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E North Ave Ext

18 (a) Funeral director Leo S. Laverty
(b) Address 1701-03 N. Patterson Park ave

DEC 30 1946 (Date rec'd by registrar) Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 28 Dec 1946 at 11:00 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 27 Dec 1946 to 28 Dec 1946 and that I last saw h[illegible] alive on 28 Dec 1946

| Immediate cause of death | Duration |
|---|---|
| Cardiac Insufficiency | |
| Due to Arteriosclerosis C.V. Dis | |
| Due to Congestive Failure | |
| Due to Old Senile Changes | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leyden Lacell M.D.
Address 1 E Balto St Date signed 28 Dec 46

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46975

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

186a

Registered No. G46975

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3503 Echodale Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ANDREW J. FINN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary E. Fermes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7-1893

8. AGE: Years 53 | Months 9 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Clerk Record Office

11. Industry or business Deed

FATHER
12. Name Maurice Finn
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Ella Fouge
15. Birthplace Baltimore Md

16 (a) Informant Wife
(b) Address 3503 Echodale AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31-46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Frederick Road

18 (a) Funeral director Frank V. Pikestone
(b) Address 2818 E. Balto St

19 (a) (Date received by local registrar) DEC 30 1946 (b) Registrar Williams, M.D.

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28, 1946, at 3.1M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestive Cardiac Failure
Edema + Congestion of Brain
Due to Fractured ribs
Generalized arteriosclerosis
Other Conditions Hemorrhage into right adrenal gland - traumatic
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-24-46 at ? 2 7/1 P. M.
(b) Where did injury occur? 3503 Echodale Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Fell down steps

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 12-28-46

X

G46976

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

146a

G46976 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address John St. & Lafayette Ave.
(c) Hospital or institution: Women's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County BALTO CATONSVILLE
(c) City or town Baltimore 28
(If outside city or town limits, write RURAL and give town)
(d) Street No. 20, Newberg Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mary Lorraine Betzold (Ryan)

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Francis Betzold
6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) March 16th 1917

8. AGE: Years 29 | Months 9 | Days 12/3 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business home.

FATHER
12. Name Charles T. Ryan
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Lorraine Hooper
15. Birthplace Baltimore Md.

16 (a) Informant Husband
(b) Address 20, Newberg avenue

17 (a) Burial (b) Date thereof 2-31-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md.

18 (a) Funeral director Joseph Shirley
(b) Address Fulton & Fayette

19 (a) ____ (b) ____
(Signature of local registrar) (Registrar)

DEC 30 1946

VS

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 29th 1946, at 10:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from December 25th 1946, to December 29th 1946, and that I last saw h.e.r. alive on December 29th 1946

| | Duration |
|---|---|
| Immediate cause of death Acute Cardiac failure Right sided Under anesthesia. | 30 min. |
| Due to Hemorrhage P.P. Partum | 1 hr. |
| Due to Central Placenta Previa | 22-24 Wks. |
| Other Conditions 22-24 wks P.P. Pregnancy Multipalla, Syphilis. | 22-24 Wks. |

(Include pregnancy within 3 months of death)
Date of operation Not Attended
Major findings of autopsy Placenta Previa, DX by Pelvic Exam.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Women's Hospital Date signed 12/29/46

L Davis

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G 6977

HARRY W. BELSCHNER, SR.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46H

Registered No. G 6977

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 13 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 Morling ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Belschner, Harry W. SR.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-05-5909

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Nannie Belschner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4 1872

8. AGE: Years 74 | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace Manchester, Carroll Co. Md. (Town, county, or state)

10. Usual Occupation Sheet Metal Worker

11. Industry or business

FATHER 12. Name George Leonard Belschner

13. Birthplace Germany

MOTHER 14. Maiden Name Lydia Williams

15. Birthplace Pa

16 (a) Informant Mrs. Nannie B. Belschner

(b) Address 1312 Morling Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 31-1946 (month) (day) (year)

(c) Cemetery or crematory St. Marys (Hamden)

Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3021 Falls Road

(c) Date rec'd (month) (day) (year) Huntington Williams, M.D.

DEC 30 1946

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 28 1946, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15 1946, to 12-28 1946, and that I last saw him alive on 12-28 1946.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Generalized Marked Arteriosclerosis | |
| Due to Inoperable Carcinoma Pancreas | over |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation 12-21-46

Major findings of operation: Retroperitoneal mass which may be attached to head of pancreas - inoperable

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. A. Shallenberger M.D.

Address University Hosp. Date signed 12-28-46

G46978

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

50

G46978

Registered No.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address 3217 Clifmont Ave.

(c) Hospital or institution:

8

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3217 Clifmont. Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Grace E. Kelly.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | No |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Thomas Kelly.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15th. 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 6 | 13 | hr. min. |

9. Birthplace Baltinmore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER

12. Name Thomas Stocks.

13. Birthplace N. C.

MOTHER

14. Maiden Name Catherine Burk

15. Birthplace Canada.

16 (a) Informant Mrs. Ross Marshall

(b) Address 3217 Clifmont. Ave

17 (a) Burial (b) Date thereof Dec. 28 46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balair Rd.

18 (a) Funeral director Geo. M. Fink & Son

(b) Address 811 N. Wolfe St

19 (a) DEC 30 1946 (b) Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 2

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28th 1946 at 7am M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1946, to Dec 28 1946 and that I last saw her alive on Dec 27 1946.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of left Breast with metastasis | |
| Due to | |
| Due to | |
| Other Conditions Anemia Arteriosclerosis | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Walter A Anderson M. D.

Address 300 Seamon Bldg Date signed 12-29-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G46979

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V83a

Registered No. G46979

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1700 W. Mulberry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits write RURAL and give town)
(d) Street No. 1700 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Samuel Johnson

3 (b) If veteran, name war I

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1886

8. AGE: Years 60 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Samuel Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Annie
15. Birthplace Md.

16 (a) Informant Mary Johnson
(b) Address Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-1946 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 Schroeder St

19 (a) DEC 30 1946 (Date rec'd by registrar) (b) Registrar

V S

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/28/46 19 , at 3 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/25/46 19 to 12/28/46 19 , and that I last saw h[illegible] alive on 12/28/46 19 46

Immediate cause of death Cerebral Hemorrhage — Duration 1 week

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. W. Dechtman, Jr. M.D.

Address 416 N. Gilmor St Date signed 12/30/46

X

G46980

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 122a

G46980 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1129 N. Mount St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertie Harris (Temple) (White)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Willis Harris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-30 76

8. AGE: Years 70 | Months x | Days x7 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Laundry Work

11. Industry or business

FATHER
12. Name Randall White
13. Birthplace Va

MOTHER
14. Maiden Name Martha Jones
15. Birthplace Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-46 (month) (day) (year)

(c) Cemetery or crematory Mt Jon
Location Md

18 (a) Funeral director Geo. G. Nelson
(b) Address 1303 Pressteman St

19 (a) (b)
(Signature of Registrar) Registrar

DEC 30 1946

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Dec 1946, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 27 Dec 19 46 to 27 Dec 19 46, and that I last saw h[illegible] alive on 27 Dec 19 46.

| | Duration |
|---|---|
| Immediate cause of death: Gangrene of bowel | 7 |
| Due to: Strangulated femoral hernia | 10 days |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)

Date of operation 27 Dec 46

Major findings of operation: Same

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard C. Clay M. D.
Address Johns Hopkins Hosp Date signed 27 Dec 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46981

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

131a

Registered No. G46981

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8d

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 Homewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Johnginis

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | S |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16, 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 4 | 12 | hr. min. |

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Richard Xanginis
13. Birthplace Balto

MOTHER
14. Maiden Name Maria Nagel
15. Birthplace Balto.

16 (a) Informant above
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md.

18 (a) Funeral director H. W. Mears & Son
(b) Address 805 N. Calvert St.

19 (a) (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-28 1946 at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1946 to 12-28 1946. and that I last saw h[illegible] alive on 12-28 1946.

Immediate cause of death Resp. Fail

Due to Pul. Edema

Due to Uremia

Other Conditions Nephrosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Mercy Hosp. Date signed 12-31

VS 150

X

G46982 G46982

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 4812

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4633 Asbury Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4633 Asbury Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lillie May Schmidt

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-20-7127

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife Charles E Schmidt

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Apr 30 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 7 9 | 29 | hr. min. |

9. Birthplace Westminster
(Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name Samuel Knight
13. Birthplace Westminster Md

MOTHER
14. Maiden Name Martha Ellen Knight
15. Birthplace Taneytown Md

16 (a) Informant Helen Merryman
(b) Address 4633 Asbury Ave

17 (a) Burial (b) Date thereof Jan 1 '47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cemetery
Location New Oakland Cemetery Co

18 (a) Funeral director Wm Berryman & Sons
(b) Address Reisterstown, Md

19 (a) (b) Westminster Md
(Date received by local registrar) DEC 30 1946

VS

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29, 1946, at 2 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1946 to Dec 29 1946, and that I last saw her alive on Dec 28 1946.

| Immediate cause of death | Duration |
|---|---|
| Cancer of the uterus | 6 months |
| Due to | |
| Due to | |
| Other Conditions Arteriosclerosis | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury CHARLES V. SERVIK

23. Signature Charles V. Servik M. D.
Address 4200 Pentwood Ave Date signed 12/30/46

X

G46983

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 469

G46983 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Fayette & Caldcleugh
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 70 years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3615 Buena Vista Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** George A. Appel

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | married |

6 (b) Name of husband or wife Anna R. Appel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/19/1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 yrs | 2 | 9 | hr. min. |

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Recorder of Wills
11. Industry or business

FATHER
12. Name Wellaid Appel
13. Birthplace

MOTHER
14. Maiden Name Carolyn Henze
15. Birthplace

16 (a) Informant Anna R. Appel
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-46 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore

18 (a) Funeral director Frank H. Seitz
(b) Address 8147 36 St.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 30 1946 Huntington Williams M.D.

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 12/28 1946, at 3:?? M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 12/27 1946, to 12/28 1946 and that I last saw him alive on 12/28 1946

Immediate cause of death Cholemia

Due to Cancer of the Head of the Pancreas

Due to

Other Conditions Gall. bladder attack
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

| Duration |
|---|
| 10 min |
| 2:50 P.M. to 3:00 P.M. |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23.** Signature Stanley B. Kleyamowe M.D.
Address Franklin Sq. Hosp. Date signed 12/30/46

G46984

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G46984
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bordens 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 534 W Hoffman (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Sturdivant Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | W |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | | | hr. min. |

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Henry Sturdivant

13. Birthplace Md

MOTHER 14. Maiden Name Not Known

15. Birthplace

16 (a) Informant

(b) Address 534 W Hoffman

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-2-37 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.

Location Baltimore, Md

18 (a) Funeral director Mt. Travers Ft. Howard

(b) Address 518 W. Biddle St

19 (a) (Date received by Registrar) (b) Huntington Williams M.D. Registrar

DEC 30 1936

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/29/36 19 , at 2:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Ward, M.D. Medical Examiner.

Date signed 12/29/36

G46985

BALTIMORE CITY HEALTH DEPARTMENT G46985

# CERTIFICATE OF DEATH 1362

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospital
(d) Length of stay in hospital or inst. (yrs.) mos., or days) 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give county)
(d) Street No. City Hospitals
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ralph White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 45 Months | Days | If less than one day hr. min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Not known
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Russell Munters
(b) Address 1212 Druid Hill Ave

17 (a) Burial (b) Date thereof 12-30-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Mrs Francis H. Hensley
(b) Address 518 W. Biddle St

19 (a) Dec 30 1946 (b) Huntington Williams, M.D.
(Date received by registrar) (Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 25 1946, at 9 20 P M

21. I certify that I took charge of the remains described above, held an Aug Ed Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William S Kefauver M.D.
Medical Examiner
Date signed Dec 27, 1946

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46986

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 126

G46986 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Fairmont + Broadway
(c) Hospital or institution: Church Home + Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County City
(c) City or town Baltimore (18)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2050 Robb Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Annie Kappes.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband ~~or wife~~ ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1857

8. AGE: Years 87 | Months 6 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Eckhardt
13. Birthplace Europe - (county unknown)

MOTHER
14. Maiden Name Margaret Renner
15. Birthplace Virginia

16 (a) Informant Mrs Bessick
(b) Address 2050 Robb St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 30 46 (month) (day) (year)
(c) Cemetery or crematory Bulls Elm
Location North Ave

18 (a) Funeral director L. Hegmann & Son
(b) Address 34 S. Broadway
(By whom signed) Huntington Williams, M.D. Registrar

19 (a) (Filed by registrar) DEC 30 1946

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25, 1946 at 11 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21 1946 to Dec 25 1946 and that I last saw her alive on Dec 25, 1946

Immediate cause of death Peritonitis
Rupture of Gall Bladder

| Duration |
|---|
| |
| ? |
| |
| |
| |
| |

Due to Cholelithiasis w. Stone in Common duct - Empyema
Due to Gall Bladder.

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A Rossi M. D.
Address Church Home & Hospital Date signed 26 Dec 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46987

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G46987 Registered No. 83a

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Eutaw Sts.
(c) Hospital or institution: Union Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 906 Bonaparte Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Mrs. Ann Lecas (ANN ELIZABETH LECAS)

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: 217-07-7894

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | M |

6 (b) Name of husband or wife Thomas Lecas
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1907

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 39 | 10 | 4 | hr. min. |

9. Birthplace RED BURN, PENNA. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER — 12. Name David Mac BLANE
13. Birthplace Scotland

MOTHER — 14. Maiden Name Agnes F. Hutchinson
15. Birthplace Scotland

16 (a) Informant Mr. Thomas M. Lecas
(b) Address 906 Bonaparte Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-2-47 (month) (day) (year)
(c) Cemetery or crematory North Union Cemetery
Location Canton, Pa.

18 (a) Funeral director HENRY SANDER & SONS INC.
(b) Address NORTH AVE. & BROADWAY

DEC 30 1946 (a) Received by registrar (b) Clayton Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/29 1946, at 7:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22 1946 to 12/29 1946 and that I last saw h[illegible] alive on 12/29 1946

Immediate cause of death Endocarditis, Lupus Erythematosus — Duration

Due to Intraventricular hemorrhage

Due to Brain tumor

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12/28/46

Major findings of operation Intraventricular hemorrhage

of autopsy: Pending

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Fischer, M.D.
Address Union Hospital Date signed 12/29/46

VS 150

G46988

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48 R

G46988 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1119 N. Wolfe St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 N. Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Celia Stanton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | col | Married |

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12-1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 1 | 16 | hr. min. |

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name John Logan
13. Birthplace Va

MOTHER
14. Maiden Name Alberta Logan
15. Birthplace Va

16 (a) Informant John Stanton
(b) Address 1119 N Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A B Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E Preston St

19 (a) (Date rec'd by) (b) Registrar

DEC 20 1946

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 20th 1946 at 10.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19th 1946 to Dec 21st 1946 and that I last saw h alive on Dec 21st 1946

Immediate cause of death Cerebral Edema

Duration 3

Due to

Due to

Other Conditions Toxemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward L. Lapsley M. D.
Address 8220 Bond Date signed 12/20/46

G46989

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 186a

G46989 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2910 Auchentoroly Terr.
(c) Hospital or institution: 13-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Auchentoroly Terr.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Henry L. A. Klitsch

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife: Christina R. Klitsch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11, 1864

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | 0 | 18 | hr. min. |

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Retired mail carrier
11. Industry or business

FATHER
12. Name Henry Klitsch
13. Birthplace Germany

MOTHER
14. Maiden Name ? Heiser
15. Birthplace Germany

16 (a) Informant Mrs. Edna Farber
(b) Address 3712 Nortonia Rd.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12/31/46 (month) (day) (year)
(c) Cemetery or crematory Greenmount Crem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Registrar) DEC 30 1946 (Registrar) Baltimore, Md.

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 29 Dec. 1946, at 4:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to Fall in home

Other Conditions Arteriosclerotic Heart Disease.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-29-46 ? M.
(b) Where did injury occur? 2910 Auchentoroly Terrace
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell downstairs

23. Signature Wm. N. Kamman, Jr. M.D.
Medical Examiner
Date signed 29 Dec. 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46990 B-106204

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

92c

Registered No. G46990

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo. 6days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 123 N. Green Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Joseph Frances Conrad

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Divorced |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17-1893

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | 2 | 11 | hr. min. |

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Distributor
11. Industry or business Gannon Co., Frederick St

FATHER
12. Name Joseph Conrad
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Burns
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12-31-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.
18 (a) Funeral director Frank Ovach & Son
(b) Address 900N. Chester St.,

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 30 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 28- 1946, at 3.30AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-22- 1946 to 12-28 1946, and that I last saw him alive on 12-28 1946.

Immediate cause of death Resp. Failure. — Duration

Due to Pulmonary Emboli — Duration

Due to Cerebral Embolism — Duration

Due to Rheumatic aortic & Mitral Disease. — Duration

Other Conditions ? Subacute Bacterial Endocarditis — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert A. Huber M. D.
Address Balto. City Hosps Date signed 12-28-46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46991

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1946

Registered No. G46991

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4006 Park Heights Ave.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4006 Park Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Floyd Eugene Patterson

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Emily Patterson
6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) March 11, 1910

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 36 | 9 | 18 | hr. min. |

9. Birthplace Toyah, Texas (Town, county, and state)
10. Usual Occupation Stock Clerk
11. Industry or business Dept. Store

FATHER
12. Name Floyd C. Patterson
13. Birthplace Texas

MOTHER
14. Maiden Name Ethel Powell
15. Birthplace North Carolina

16 (a) Informant Mrs. Emily Patterson
(b) Address 4006 Pk. Hgts. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/30/46 (month) (day) (year)
(c) Cemetery or crematory
Location Enfield, ~~Texas~~ N.C.

18 (a) Funeral director Le Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) (Signature of Registrar) (b) Registrar

DEC 30 1946

VS 150

**MEDICAL CERTIFICATION** P.

20. DATE OF DEATH Dec. 29th 1946 at 9:45 M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 29 1946 to Dec. 29 1946 and that I last saw h im alive on Dec. 29 1946.

Immediate cause of death Coronary Thrombosis — Duration

Due to Hypertensive C.V.D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles H. Williams M. D.
Address 1331 Reisterstown Pikesville, Md. Date signed 30 Dec 1946

Huntington Williams, M.D.

Howard L. Chaillis, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-100931 G46992

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G46992

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7mos-29days
(e) Length of stay in Baltimore (yrs., mos., or days) 2yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 522 N. Bradford Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Nellie Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F. | Colored | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26- 1925

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 21 | 2 | 2 | hr. min. |

9. Birthplace S.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Butler
13. Birthplace S.C.

MOTHER
14. Maiden Name Mary Butler
15. Birthplace S.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof Dec 30 1946 (month) (day) (year)
(c) Cemetery or crematory Lakeview Cem
Location Baltimore Md

18 (a) Funeral director Robert Hartig
(b) Address 928 Druid Hill Ave

19 (a) (b) Registrar

DEC 30 1946
VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 28- 1946, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-29- 1946, to 12-28 1946, and that I last saw her alive on 12-28-46 1946.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Tbc., far-advanced | 10 Mos. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not obtained

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Hunt M. D.
Address Balt. City Hosp. Date signed 12-28-46

Dr. Janney
7101 Harford Road

G46993

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

93c

Registered No. G46993

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2923 Christopher Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2923 Christopher Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Amanda L. Cole

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widowed |

6 (b) Name of husband or wife Charles F. Cole
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 13, 1864

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | 9 | 16 | hr. min. |

9. Birthplace Balto. Co. Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Elisha Christopher
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Louise Erdman
15. Birthplace Md.

16 (a) Informant Mrs. J. Louise Hess
(b) Address 2923 Christopher Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/1/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

DEC 30 1946

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 29th, 1946 at 5:50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1944 to Dec. 29, 1946 and that I last saw her alive on Dec. 29, 1946

Immediate cause of death: Myocardial Heart Disease — Duration 2 years

Due to

Due to

Other Conditions Chronic Arthritis Decubitus Ulcers
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature Nathan Janney M.D.
Address 7101 Harford Rd. Date signed 12/30/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46994

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G46994

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital DOA

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 435 Culver St (29)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Julius H. Deckert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Marie S. Deckert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 11, 1898

8. AGE: Years 47 | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace Oakto. Md
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Globe Brew. Co.

FATHER
12. Name Rheinhart Deckert
13. Birthplace Md.

MOTHER
14. Maiden Name Edna —
15. Birthplace Md.

16 (a) Informant Mrs. Marie Deckert
(b) Address 435 S. Culver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/46. (month) (day) (year)

(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Writtle
(b) Address 4101 E Edmondson ave

19 (a) DEC 30 1946 Washington Nat'l Ins. Co.

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 28 1946, at 5-25 P M

21. I certify that I took charge of the remains described above, held an Autopsy/Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William S. Siegrist M.D.
Medical Examiner.
Date signed Dec 28, 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46995

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

93D

Registered No. G46995

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3810 Gelston Dr.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3810 Gelston Pl.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sarah P. Dougherty

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F. | W. | Widow |

6 (b) Name of husband or wife Patk Chas. H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1859

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 87 | 9 | 21 | hr. min. |

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Benjamin Barker
13. Birthplace England

MOTHER
14. Maiden Name Elizabeth Wellen
15. Birthplace Md

16 (a) Informant James J. Dougherty
(b) Address 3810 Gelston Pl.

17 (a) Burial (b) Date thereof Jan. 2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Harry H. Whistle
(b) Address 4101 Edmondson ave

19 (a) (b)
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/29/46 19 , at 10 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to 12/29 1946 and that I last saw h[illegible] alive on 12/29 1946

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 12/28/46 |
| Due to Hypertensive & Arteriosclerotic Cardio | |
| Due to Ureachial Disease | 10 yrs |

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. E. Roach

Address 3629 Edmondson Ave Date signed 12/30/46 M. D.

VS 1-50 DEC 30 1946

Huntington Williams, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46996

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93E

✓ G46996 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1007 Bartolow St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 N Bartolow St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Ward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Emma Barbara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 18, 1863

8. AGE: Years 83 | Months 1 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Painter

FATHER
12. Name Bernard Ward
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Dehr
15. Birthplace Ireland

16 (a) Informant Mary Booth
(b) Address 1007 N. Bartolow St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral Cem
Location 4300 Frederick Rd.

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St

(Date received by registrar) (Registrar)

DEC 30 1946

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1946 at 9:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1940 to Dec 27 1946, and that I last saw him alive on Dec 26 1946

Immediate cause of death Myocardial Insufficiency

Due to Pulmonary Edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E. Stewart M. D.

Address 257 W. Lanvale St Date signed Dec 27 46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46997 ✓ G46997

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 107

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 120 S. Gilmor St 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8 mo

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 120 S. Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** PATRICK J. ISABELLA

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | White | Single |

6 (b) Name of husband or wife ✓

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29th 1915

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 31 | 5 | 1 | hr. min. |

9. Birthplace Albany N.Y. (Town, county, and state)

10. Usual Occupation Sign Painter

11. Industry or business

FATHER
12. Name Frank Isabella
13. Birthplace N.Y.

MOTHER
14. Maiden Name Johanna Petrone
15. Birthplace N.Y.

16 (a) Informant Pasquale De Masi
(b) Address Albany N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Albany N.Y.
Location Albany N.Y.

18 (a) Funeral director John J. Crowley & Son
(b) Address 901-03 Hollins St.

19 (a) [illegible] (Date rec'd by registrar) [illegible] Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29 1946, at 1:10 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 12/30/46

DEC 30 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46998

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

61

G46998 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore 23
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1830 W. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Eliza NELSON BOWEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Joseph Owen F.

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) April 1869

8. AGE: Years 77 | Months 8 | Days - | If less than one day ____ hr. ____ min.

9. Birthplace Owing's Mills, Md.
(Town, county, and state)

10. Usual Occupation Baltimore Transit

11. Industry or business Company

FATHER
12. Name Thomas Bowen
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary A. Disney
15. Birthplace Maryland

16 (a) Informant Josephine F. Bowen
(b) Address 1830 W. Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 31 Dec 46 (month) (day) (year)

(c) Cemetery or crematory Mt Pleasant
Location Owings Mills - Md

18 (a) Funeral director E. D. Shipley & Son
(b) Address 1300 Eutaw Place

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

DEC 30 1946 Hamilton Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29 1946, at 12:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9 1946 to 12-29 1946 and that I last saw h[illegible] alive on 12-28 1946

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia Bilateral | |
| Due to Diabetes Mellitus | |
| Due to | |
| Other Conditions A.V. Heart block | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nelson Hammond M. D.

Address 11 So. Gay St. Date signed 12-30-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G46999

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

V 85

G46999 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Avenue
(c) Hospital or institution: Jenkins Memorial Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 East Mulberry Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Agnes Renehan

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 10 | 25 | hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Bookkeeper

11. Industry or business

FATHER
12. Name William Renehan
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary August
15. Birthplace Maryland

16 (a) Informant Hosp Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md

18 (a) Funeral director Henry McCulloh Jenkins Sons Co
(b) Address McCulloh & Orchard Sts

19 (a) (Date rec'd by registrar) (b) Hyattsville, Md.

DEC 30 1946

VS 158

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 29 1946 at 12.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death — Cardiac failure - 5

Due to

Due to

Other Conditions Hypertrophic cirrhosis Pelvic mass 4

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| PETIT MAL |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D W Mintz M D
Address Stagna Date signed 12/31/46

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47000

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

✓ G47000 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2318 N Calvert St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth L Manley

3 (b) If veteran, name war W | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 10 | 28 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Nicholas S Manley
13. Birthplace Md

MOTHER
14. Maiden Name Louisa J Simcoe
15. Birthplace Md

16 (a) Informant Sara M Rose
(b) Address 2318 N Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/46 (month) (day) (year)
(c) Cemetery or crematory Methodist
Location North East Md

18 (a) Funeral director Wilson Goldie
(b) Address 219 E Fort Ave

19 (a) Dec 30 1946 (Date received by registrar) Thos. Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 29 1946, at 6 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1946 to Dec 29 1946, and that I last saw h[illegible] alive on Dec 28 1946.

Immediate cause of death: Cerebral Thrombosis & Paralysis. Left Side — Duration 1 mo
Due to: Generalized Arteriosclerosis — Duration 5 yrs
Due to: — Duration
Other Conditions: Chronic Myocarditis — Duration 5 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Nathaniel M Beck M.D.
Address 100 E 73rd St Date signed Dec 30-46

VS 150

G47001

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47001 Registered No. X 94a

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) City, Maryland Baltimore, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: The Seton Institute
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 yrs - 6 mo. - 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs - 6 mo. - 14 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pennsylvania (b) County
(c) City or town Dallas (If outside city or town limits, write RURAL and give town)
(d) Street No. Villa St. Teresa (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Martina O'Brien

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 16 1882 64 yrs - 11 mo. - 13 days

8. AGE: Years 64 Months 11 Days 13 If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation teacher

11. Industry or business

MOTHER / FATHER

12. Name John O'Brien

13. Birthplace Ireland

14. Maiden Name Mary Jane O'Hare

15. Birthplace Ireland

16 (a) Informant The Seton Institute

(b) Address 6420 Reisterstown Road, Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 30/46 (month) (day) (year)

(c) Cemetery or crematory Mother of Mercy

Location Cresson Pa

18 (a) Funeral director Schwab Mortuary Co.

(b) Address [illegible]

DEC 30 1946 (b) [illegible] Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29 1946, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-15 1935, to 12-29 1946, and that I last saw h.e.r. alive on 12-29 1946

Immediate cause of death myocardial infarct — Duration 10 days

Due to

Due to

Other Conditions schizophrenia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address 33 W. Madison St. Baltimore

VS 150

G47002 ✓ G47002

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 12/a

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Linden & Madeira Pls
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 209 W. Mulberry (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country China

**3 (a) FULL NAME** Tom You (TOM YOU)

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: Yellow
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: (Deceased in China)
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) About 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| Abt 74 | — | — | hr. min. |

9. Birthplace China (Town, county and state)
10. Usual Occupation Noodle Mfr
11. Industry or business Noodles

FATHER
12. Name unknown
13. Birthplace China

MOTHER
14. Maiden Name unknown
15. Birthplace China

16 (a) Informant Tom Yoke - (cousin)
(b) Address 209 W Mulberry

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-46 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn

18 (a) Funeral director Stewart Mayo Co.
(b) Address 1086 N Howard St.

19 (a) (Date received by registrar) (b) Registrar

DEC 30 1946

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 27th 1946, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27th 1946 to Dec 27th 1946, and that I last saw h alive on 19

| Immediate cause of death | Duration |
|---|---|
| Auricular fibrillation | |
| Due to C.R.V. disease | 4 hrs. |
| Due to | |
| Other Conditions Uremia (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. E. Gonzales M. D.
Address Maryland G. Hosp. Date signed 12/27/46

For S.D.J.R. Davis, by Howard J. Malecjo, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47003

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X ✓ 94a

Registered No. G47003

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette Sts
(c) Hospital or institution: Franklin St Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town 3707 Century Ave (If outside city or town limits, write RURAL and name town)
(d) Street No. English Consul (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Arthur B. Crowther

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-1810A

4. Sex M. | 5. Color or race Wht | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Deceased.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1st 1878

8. AGE: Years 68 | Months 2 | Days 28 | If less than one day hr. min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name John S. Crowther

13. Birthplace England

MOTHER 14. Maiden Name Not Known.

15. Birthplace England

16 (a) Informant Jas Crowther

(b) Address 214 Mallow Hill Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/1/47 (month) (day) (year)

(c) Cemetery or crematory Deltaville Va.

Location

18 (a) Funeral director Geo H. Leppbach

(b) Address 25 N. Fremont St.

19 DEC 30 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 29 Dec. 1946, at 6:NP. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D. Medical Examiner.

Date signed 29 Dec. 1946

VS 151

X

G47004

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93

G47004 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2523 Harlem Avenue
(c) Hospital or institution: 16-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County **********
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2523 Harlem Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ANNA T. MAHRER

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July, 28th 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 5 | 0 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired --Clerk

11. Industry or business U.S.F& G.

FATHER
12. Name John W. Mahrer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary R. Peacock
15. Birthplace Baltimore, Md.

16 (a) Informant Clarence R. Mahrer
(b) Address 2523 Harlem Ave.

17 (a) Burial (b) Date thereof Dec. 31 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Westeern Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miles Lamotte
(b) Address 4610 Liberty Heights Ave.

19 (a) (Date received by registrar) (Huntington Williams) Registrar

VS 150

**MEDICAL CERTIFICATION** P

**20. DATE OF DEATH** Dec. 28th. 1946, at 9.50 M

**21.** I certify that death occurred on the date above stated; that I attended deceased from September 1945 to December 1946, and that I last saw h-r alive on 12-28 1946.

Immediate cause of death: Hypertension C-V-D & Acute Congestive Failure — Duration: 7 years

Due to: Generalized Arteriosclerosis — 10 days

Due to: Cerebral Hemorrhage - Old — 1½ years

Other Conditions: None

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: Not Done

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jay Coleman M. D.
Address 1201 Poplar Grove St. Date signed 12-29-46

G47005 BC 91 6525

# BALTIMORE CITY HEALTH DEPARTMENT

TH. 107082 **CERTIFICATE OF DEATH** 159 Registered No. G47005

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3032 Ascension Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy (Scurry ) Viola

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Col. | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25/1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | 3 hr. 5 min min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Viola
15. Birthplace

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( records)

17 (a) Cremated (b) Date thereof 12-27-46
[redacted] cremation [redacted) (month) (day) (year)
(c) [redacted] crematory Baltimore City Hosp.
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

DEC 31 1946 Washington Williams, MD
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION** A M

**20. DATE OF DEATH** December 25th 1946, at 6.30 M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec/25/46 19 to Dec. 25 1946 and that I last saw h im alive on Dec.25/ 19 46

| Immediate cause of death | Duration |
|---|---|
| Atelectasis | 2 hrs |
| Due to | |
| Due to Prematurity | 2 hrs |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23.** Signature Julian P. Griffin M. D.
Address Balt City Hosp Date signed 27 Dec 1946

VS 150

G47006 NGD 106654 BC# 064103

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 119a

Registered No. G47006

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 17

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1437 Parrish Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Girl Lyles (Esther)

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | Col. | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 17 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Robinson
13. Birthplace Md.

MOTHER
14. Maiden Name Esther Lee
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof 12-27-46 (month) (day) (year)
(c) crematory Balto. City Hospitals
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

19 (a) DEC 31 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 23 1946, at 6:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 6 1946 to Dec. 23 1946, and that I last saw her alive on Dec. 23 1946.

| Immediate cause of death | Duration |
|---|---|
| Diarrhea | 7 days |
| Due to | |
| Due to | |
| Other Conditions Prematurity | 17 days |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Terminal Bronchopneumonia

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julian P. Pfeffer M.D.
Address Balt. City Hosp. Date signed 2 Jan 1946

VS 150

G47007 BC# G 64714 CWK-106846

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

V 30F

Registered No. G47007

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 W. Mulberry Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy Jones, Salena

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 13-1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 4 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Mac Jones
13. Birthplace South Carolina

MOTHER
14. Maiden Name Salena Owens
15. Birthplace South Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Cremated (b) Date thereof 12-27-46
(cremation, [redacted] (month) (day) (year)
(c) [redacted] crematory Balto. City Hospitals
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

19 DEC 31 1946 Hunterton Williams, M.D. Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** December 17 19 46 at 6:45 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec. 13 1946, to Dec. 17 1946, and that I last saw h. imalive on Dec. 17 1946.

| Immediate cause of death | Duration |
|---|---|
| Syphilis | postation |
| Due to | |
| Due to | |
| Other Conditions Prematurity | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Syphilis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23. Signature** Julian V. Shaffer M. D.
Address Balt City Hosp Date signed 29 Dec 1946

VS 150

G47008 BC# G47008

BALTIMORE CITY HEALTH DEPARTMENT

FL - 106979 G65415 CERTIFICATE OF DEATH 159 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6hrs. 7 mins
(e) Length of stay in Baltimore (yrs., mos., or days) 6hrs. 7 mins

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1833 E. Chase St -13
(If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Finney - LaNae Fanny

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | 6 hr. 7 min. |

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER'S
12. Name Leon Finney
13. Birthplace Md.

MOTHER'S
14. Maiden Name LaNae Fanny Davis
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof 12-27-46
(Burial, cremation, removal) (month) (day) (year)
(c) Cemetery or crematory Balto. City Hospitals
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

DEC 31 1946 (b) Huntington Williams, M.D.
(Date rec'd 1946) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20 1946 at 2.35AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 19 1946 to Dec. 20 1946, and that I last saw h. alive on Dec. 20 1946.

| Immediate cause of death | Atelectasis | Duration 4 hrs |
|---|---|---|
| Due to | | |
| Due to | | |
| Other Conditions | Prematurity | 4 hrs |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julian P. Griffin M.D.
Address Balt City Hosp Date signed 29 Dec 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(47-008815) 47003

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH √13B

Registered No. 47003

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 18 da 12
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 W. 22nd. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ralph Weldon Mayfield

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. Yes |
|---|---|

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | Widowed |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 4 | 19 | hr. min. |

9. Birthplace La (Town, county, and state)
10. Usual Occupation Caretaker of Shop
11. Industry or business 2015 N. Charles St.

FATHER
12. Name Jim Mayfield
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balty. City

18 (a) Funeral director Charley K. Low
(b) Address 20 N. Mad. Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 31 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1946, at 8.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 4 1946 to Dec. 19 1946 and that I last saw him alive on Dec. 19 1946.

| | Duration |
|---|---|
| Immediate cause of death Pulmonary Tuberculosis far advanced | 3 months known |
| Due to | |
| Due to | |
| Other Conditions Benign Prostatic Hypertrophy; Cystitis (Include pregnancy within 3 months of death) | Unknown |

Date of operation
Major findings of operation:
of autopsy: Same

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. J. Bird M. D.
Address Balto City Hosp Date signed 12-30-46

X

G47010

DC# G65463

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 157E

G47010 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: FRANKLIN SQUARE HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 3

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 408 N. Kenwood Ave (If rural give location)
(e) Citizen of foreign country? A (Yes or No) If yes, name country

**3 (a) FULL NAME** BABY BOY BERTHOLDT

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-20-46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 3 2 | hr. min. |

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Milton Berthold
13. Birthplace Md

MOTHER
14. Maiden Name Mildred Vogt
15. Birthplace Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 26 1946

18 (a) Funeral director (Commissioner of Health)
(b) Address

19 DEC 31 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 22 DEC. 1946, at 12:50 A.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from 12-20 1946, to 12-22 1946, and that I last saw h.IM. alive on 12-22 1946.

| Immediate cause of death | Duration |
|---|---|
| UNKNOWN | |
| Poss. Congenital Heart | |
| Due to Disease | 1 day |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edgar H. Santmyer
Address Chief Res. Obs. Hosp. Date signed 12/24/46

G47011

BALTIMORE CITY HEALTH DEPARTMENT X

# CERTIFICATE OF DEATH 160a

G47011
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County A A Co
(c) City or town Ft Meade
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ralph J. King

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-14-46

8. AGE: Years | Months | Days: 4 | If less than one day: hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Ralph King
13. Birthplace Pa.

MOTHER — 14. Maiden Name Edna Hanaw
15. Birthplace Calif.

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School DEC 26 1946
Baltimore, Md. Commissioner of Health

18 (a) Funeral director
(b) Address

DEC 31 1946 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

19. DATE OF DEATH Dec 15 1946 at 5 20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 16 1946 to Dec 18 1946, and that I last saw him alive on Dec 18 1946.

| Immediate cause of death | Duration |
|---|---|
| INTRACEREBRAL BIRTH INJURY | LIFE |
| Due to | |
| Due to | |
| Other Conditions ASPIRATION PNEUMONIA? (Include pregnancy within 3 months of death) | 3 days |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul H Harbin M.D.
Address Johns Hopkins Hosp. Date signed 12/19/46

VS 150

X

G47012

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

504938 / 46 B

G47012 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 N. Bullough St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Elliott Gilmore

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Black | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-22-95

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | 1 | 19 | hr. min. |

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business

FATHER
12. Name William Gilmore
13. Birthplace S.C.

MOTHER
14. Maiden Name Rosa Bellet.
15. Birthplace S.C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 30 1946

18 (a) Funeral director Commissioner of Health
(b) Address

DEC 31 1946 (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH Dec. 9 1946 at 4.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 1946, to Dec. 6 1946, and that I last saw him alive on Dec. 9 1946.

| | Duration |
|---|---|
| Immediate cause of death Pulmonary embolism & infection | 24 hrs |
| Due to Thrombophlebitis, right leg & right arm. | 6 days |
| Due to Carcinoma of stomach; generalized peritoneal & | 2 1/4 |
| Other Conditions Lymph node metastases | |

(Include pregnancy within 3 months of death)

Date of operation Dec. 2, 1946

Major findings of operation: as above

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene Lugan M. D.
Address Johns Hopkins Hospital Date signed Dec 10 46

VS 150

G47013 Birth Certificate S-66520

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47013 Registered No. 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Hrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Anne Arundel
(c) City or town Margate (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 Tamar Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby boy Smith [redacted] A.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| None | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife None
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 6:45 AM 12/25/46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| — | — | 1/6 | 4 hr. 0 min. |

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Joseph Wm Smith
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Marie Herpel
15. Birthplace Fallon, Nev.

16 (a) Informant Marie Smith
(b) Address Margate, Md

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 30 1946
18 (a) Funeral director Commissioner of Health
(b) Address
DEC 31 1946 (Date rec'd by registrar) Henrietta M. Williams Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/25 1946; at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/25 1946 to 12/25 1946. and that I last saw him alive on 10:45 AM 12/25/46

Immediate cause of death

| | Duration |
|---|---|
| Prematurity | |
| Due to Prematurity Extreme & water gilberta | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John W Magruder M. D.
Address Baltimore, Md Date signed 12/28/46

VS 150

G47014

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47014 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 9
(c) Hospital or institution: South Baltimore General 21-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7d
(e) Length of stay in Baltimore (yrs., mos., or days) 66y

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 Bouldin Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Joseph Lorlock

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | ? |

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | | | hr. min. |

9. Birthplace ? (Town, county, and state)

10. Usual Occupation ?

11. Industry or business Unknown

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School DEC 30 1946

18 (a) Funeral director Commissioner of Health

(b) Address

19 DEC 31 1946 (Date rec'd by registrar) (b) [illegible] Williams M.D. Registrar

VS 191

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/9/46 19 , at 8:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R. Davis, M.D.
Medical Examiner.

Date signed 12/10/46

G47015 BC# G 65723

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

G47015 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 518 N. Eutaw St.
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 5/60 hrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 N. Eutaw St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country No

**3 (a) FULL NAME** Anna Marie Aceno

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | — |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 24 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | 3 hr. 5 min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Severo Samonad Aceno
13. Birthplace Philippine Islands

MOTHER
14. Maiden Name Margaret Bertha
15. Birthplace Glen Arm, Md.

16 (a) Informant Margaret Bertha Aceno
(b) Address 518 N. Eutaw St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Potter's Field
Location
18 (a) Funeral director
(b) Address

University Medical School DEC 30 1946
Commissioner of Health

19 DEC 31 1946 (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 12/24/1946, at 3:35 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 12/24/1946 to 12/24/1946, and that I last saw him alive on 12/24/1946.

Immediate cause of death Cardiac — Duration
Respiratory failure
Due to Pulmonary atelectasis Bilateral
Due to
Other Conditions Prematurity
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature C. Samuel Swartz, M.D.
Address Mercy Hosp Date signed 12/27/46

VS 150

Birth Certificate

G47016

G-66403

BALTIMORE CITY HEALTH DEPARTMENT X

# CERTIFICATE OF DEATH √160c

Registered No. G47016

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Min
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Min

**2. USUAL RESIDENCE OF DECEASED**
(a) State Md Baltimore Balto. Co.
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 367 - Route 2
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy Eichelberger

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 27, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | hr. 10 min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Robert Eichelberger
13. Birthplace

MOTHER
14. Maiden Name Bertie Ayers
15. Birthplace

16 (a) Informant mother (Bertie Eichelberger)
(b) Address Box 367 Balto Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School DEC 30 1946

18 (a) Funeral director Commissioner of Health
(b) Address

DEC 31 1946 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-27 1946, at 1:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27 1946, to 12-27 1946, and that I last saw him alive on 12-27 1946

Immediate cause of death Uterine inversion — due to asphyxia — due to [illegible] fr.

Due to Uterine retention of placenta

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12-27-46

Major findings of operation:

of autopsy:

Duration: 10 Min

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Goldman, M.D.

Address 2326 Edmondson Ave Date signed 12/27/46

VS 150

G47017
AB-107157

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G47017

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1hr-05min.
(e) Length of stay in Baltimore (yrs., mos., or days) 1hr-05min

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7734 S. Cove Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Raymond Tolbert

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 8-1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 1 | 20 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Stanley
13. Birthplace Maryland

MOTHER
14. Maiden Name Virginia
15. Birthplace Maryland

16 (a) Informant Records- Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec-31-1946 (month) (day) (year)
(c) Cemetery or crematory St. Paul's
Location Baltimore Md

18 (a) Funeral director Linwood D. Covington
(b) Address 21 W. 25th St

19 (a) DEC 31 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 28-19 1946, at 10.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-28 1946, to 12-28 1946, and that I last saw him alive on 12-28 1946.

| Immediate cause of death | Duration |
|---|---|
| Acidosis, nephros | |
| Dehydration, shock | 1 day |
| Due to Bacillary dysentery | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes
Address Balt city Hall Date signed Dec 31 D

BALTIMORE CITY HEALTH DEPARTMENT

BRD 1070 647018 CERTIFICATE OF DEATH 131a Registered No. 647018

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs. 15 min.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. State Penitentiary (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie White

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years 34 | Months ? | Days ? | If less than one day hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?
13. Birthplace

MOTHER 14. Maiden Name ?
15. Birthplace

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/46 (month) (day) (year)
(c) Cemetery or crematory Leakin Park Rd
Location Baltimore Md

18 (a) Funeral director Gahagan
(b) Address 131 E. Light St.

19 (a) (b) (Date received by registrar)

VS 150 DEC 31 1946 Huntington Williams Blvd

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 22 19 46 at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 22 19 46 to Dec. 22 19 46, and that I last saw him alive on Dec. 22 19 46

Immediate cause of death: Uremia — Duration 3 days

Due to Hypertensive Cardio-Vascular renal disease — yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elmyra Bareham
Address Balto City Hosp Date signed M. 30 D. 46

X

G47019 Local Certificate # 25501

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1160 C

G47019 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: So Balto Gen Hosp 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18hr
(e) Length of stay in Baltimore (yrs., mos., or days) 18hrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
City or town Balto 30
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 E Clement St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Rude
3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12/29/46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 1 | - | - | 18 hr. min. |

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Jerrell Gordon Rude
13. Birthplace Pittsfield Mass.

MOTHER
14. Maiden Name Mary G. Hobbs
15. Birthplace Balto. Md.

16 (a) Informant K. G. Rude.
(b) Address 600 E Clement St Balto 30 Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-46 (month) (day) (year)
(c) Cemetery or crematory St Marks.
Location Highland Howard Co.
18 (a) Funeral director H C Hayes Inc Baltimore
(b) Address Edmondson Ave Md.
19 DEC 31 1946 (Date rec'd by registrar) Registration No. Williamsport, Md.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 29 1946, at 7.55 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29 1946 to Dec 29 1946 and that I last saw him alive on Dec 29 1946

| Immediate cause of death | Duration |
|---|---|
| Resp. failure | |
| due to cerebral anoxia | |
| Due to Premature separation | |
| Due to Placenta | |
| Other Conditions Prematurity | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature R. O. Eareckson M. D.
Address 30 Balto Gen Hosp Date signed 12/30/46

VS 150

G47020

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G47020

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 minutes
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 305 W. Dolphin St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mc Carthy, Charles Francis

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 10 | 20 | hr. min. |

9. Birthplace Dummerston, Vermont
(Town, county, and state)

10. Usual Occupation Bos'n

11. Industry or business Seafarer

FATHER
12. Name Patrick Mc Carthy
13. Birthplace Conn.

MOTHER
14. Maiden Name Mary Hopkins
15. Birthplace Rhode Island

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Removal (b) Date thereof 12/31/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Barre Vt.

18 (a) Funeral director E. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

(a) DEC 31 1946 (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 30 19 46 at 6:12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 30 1946 to Dec. 30 19 46, and that I last saw h im alive on Dec. 30 19 46.

Immediate cause of death Infarction myocardial — Duration TEN DAYS

Due to Coronary sclerosis with occlusion of the left — Due to descending and right coronaries — Duration UNKNOWN

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 12/30/46

VS 150

X

G47021

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 123

Registered No. G47021

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 661 W. Pratt St,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** George Balchunas or Balchinas

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Widowed |

6 (b) Name of husband or wife Anna Balchunas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Know

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | | | hr. min. |

9. Birthplace Lithuanian (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name ? Balchunas
13. Birthplace Lithuanian

MOTHER
14. Maiden Name Not Know
15. Birthplace Lithuanian

16 (a) Informant Mrs. Anna J. Kopas
(b) Address 802-F Wilson Pt. Road.

17 (a) Burial (b) Date thereof 12-31-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Road

18 (a) Funeral director John J. Grebliunckas Jr
(b) Address 1923 S. Paca St.

19 (Date rec'd by registrar) DEC 31 1946 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/29 1946, at 1 35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-26 1946 to 12-29 1946 and that I last saw h alive on 12-29 1946.

| Immediate cause of death | Duration |
|---|---|
| Massive Gastro-Intestinal Hemorrhage | 30 min. |
| Due to Cause unknown | |
| Due to | |
| Other Conditions Alcoholism, Poss. Gall Bladder Pathology | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John C. Marmon M. D.
Address Univ. Hosp. Date signed 12-29-46

VS 150

X

G47022 G47022

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 77c

Registered No. G47022

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 217 W. Lanvale St.
(c) Hospital or institution: 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) dos a
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie E. Conner

3 (b) If veteran, name war W. W. #2

3 (c) Social Security Account No. 219-12-5994

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 29th 1909

8. AGE: Years 37 | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Asst Manager-Interior Decorating

11. Industry or business Mill End Shop

FATHER
12. Name Elmer S. Conner Sr.
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name A. Elizabeth Simbel
15. Birthplace Balto. Md.

16 (a) Informant Elmer S. Conner Sr. Fm
(b) Address 128 Augusta Ave. Irving

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 12/31/46 (month) (day) (year)
(c) Cemetery or ~~crematory~~ London Park
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 DEC 31 1946 Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28, 1946 at 1 50 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Alcoholism.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur? 217 W. Lanvale St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury

23. Signature Harold J. Walder's M.D.
Medical Examiner.
Date signed 12-30-46

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47023

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1702

G47023

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 33 S. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Margaret Drenner

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-22-1884

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Donald A. Drenner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30/1926

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 20 | 7 | 29 | hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Piston Tng Dept.
11. Industry or business Bartlett Haywood Co

FATHER
12. Name James H. Ferguson
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary Rose Hellerer
15. Birthplace Baltimore Md

16 (a) Informant Georgette Drenner
(b) Address 3003 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jany 2/1947 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director Harry A Armacost
(b) Address 4204 Ritchie Hwy

DEC 31 1946 (b) (Date received by local registrar)

VS 151

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec. 29th 1946, at 12 35 A.M.

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull,
Fracture of cervical vertebra
Intra Cranial Hemorrhage

Due to

Other Conditions Multiple fractures, lacerations & bruises
(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 12/29/46 at 12:20 A.M.
(b) Where did injury occur? Brad St - 60 ft west of Arlington
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Passenger in auto that struck parked auto

**23.** Signature Howard J. Hadley M.D.
Medical Examiner.
Date signed 12-30-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47024

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 1937

G47024
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1213 Light St. 23
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 28 E. Hamburg St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** George R. Kenshaw

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 9 | 10 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Floyd Kenshaw
13. Birthplace Md

MOTHER 14. Maiden Name Margaret Robinson
15. Birthplace

16 (a) Informant Miss Mary Herget
(b) Address 1304 S. Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/1/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location E. End of North Ave

18 (a) Funeral director John F. Henry Inc.
(b) Address 26 Light St.

19 (a) DEC 31 1946 (Date received by Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 29 1946, at 12.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 17 1946 to Dec 29 1946, and that I last saw h[er] alive on Dec 29 1946

| Immediate cause of death | Duration |
|---|---|
| acute Cardiac Insufficiency | |
| Due to Arterio sclerotic Heart Disease | |
| Due to Generalized Arterio sclerosis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard S. Rude M. D.
Address 1304 Bolton Ave Signed 12/31/46

VS 150

Birth Certificate
G17025
G-65880

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓107

Registered No. G47025

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital 20-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2583 Frederick Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Darlene Estelle Woodland

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | single |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/18/46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 0 | 0 | 11 | hr. min. |

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation infant
11. Industry or business

FATHER 12. Name Ritchie Woodland
13. Birthplace Va

MOTHER 14. Maiden Name Agnes Heath
15. Birthplace Balto

16 (a) Informant Ritchie Woodland
(b) Address 2583 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Frederick Ave

18 (a) Funeral director Robert L Brooks
(b) Address 1338 Hollins Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams

DEC 31 1946

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/29/46 19 at 11 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/29/46 19 to 12/29/46 19, and that I last saw h alive on 12/29/46

Immediate cause of death: Pneumonia — Duration 1 day
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy: none

over

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E H North J M. D.
Address Bon Secours Hosp Date signed 12/29/46

G47036

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V137a

Registered No. G47036

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 921 E Baldwin St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Peter P. Novak NOVAK.

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-5400

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M. | W | M |

6 (b) Name of husband or wife Wilhelmina Lohr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26 - 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 6 | 3 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Brass Copper & Brass Co

FATHER 12. Name John

13. Birthplace Ger.

MOTHER 14. Maiden Name agnes novak.

15. Birthplace Ger.

16 (a) Informant Wife

(b) Address 921 E Baldwin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/1/47 (month) (day) (year)

(c) Cemetery or crematory Lehnerts

Location Bonnett St

18 (a) Funeral director Clarence T. Hoffmann

(b) Address 1639 Broadway

19 (a) (Date rec'd by registrar) (b)

VS Form DEC 31 1946 Huntington, Md.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 29 December 1946 at 1:12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/5/46 19 to 12/29/46 19, and that I last saw h[illegible] alive on 12/29/46 19

Immediate cause of death Cardiac Failure — Duration

Due to Sufficiency

Due to Pyelonephritis

Other Conditions Benign Prostatic Hypertrophy Bronchitis

(Include pregnancy within 3 months of death)

Date of operation 12/18/46

Major findings of operation: S.P.H.

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Asher Holland M. D.

Address Union Hospital Date signed 12/29/46

G47027

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47027 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland.
(c) Hospital or institution: SINAI HOSPITAL. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Green Spring Manor Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Florence S. Heller

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Bernard A. Heller. If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1882.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 6 | 17 | hr. min. |

9. Birthplace Atlantic City, N.J. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Abraham Simon,
13. Birthplace Germany.

MOTHER
14. Maiden Name Emma Kaufman,
15. Birthplace Phila. Pa.

16 (a) Informant Mr. Bernard Heller,
(b) Address 2015 Greenberry Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1.1.47. (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom
Location Balto. Md.

18 (a) Funeral director Harold Sonneborn & Son
(b) Address 1902 Eutaw Place.

19 (a) (Name and title of person) (b) Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-30-46 19 , at 3.47 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27 1946 to 12-30 1946.
and that I last saw h alive on 12-31- 1946
Immediate cause of death Circulatory failure.

| | Duration |
|---|---|
| Due to Myocardial degeneration | |
| Due to Coronary Sclerosis | |
| Other Conditions Acute Myocardial infarction - obliterating pericarditis | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bertha Roden M. D.
Address Sinai Hosp Date signed 12-30-46

G47028

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47028 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3400 Taney Road.
(c) Hospital or institution:

27-20

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3400 Taney Road. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** HANNAH ALEXANDER.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William Alexander.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 10, 1858.

8. AGE: Years 88 | Months 9 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Isaac Harzberg,
13. Birthplace Germany.

MOTHER
14. Maiden Name Barbara Frank,
15. Birthplace Germany.

16 (a) Informant Mrs. Julius Kemper,
(b) Address 3400 Taney Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1.2.47. (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom
Location Balto. Md.

18 (a) Funeral director Harris Sonnenschein & Son
(b) Address 1902 Eutaw Place.

19 (a) (Date rec'd by registrar) (b)

Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 30th. 1946, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946, to Dec 30 1946, and that I last saw h[illegible] alive on Dec 31 1946

Immediate cause of death: Cerebral Embolism — Duration: 2 hours
Due to: Chronic Myocarditis — Duration: Several yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Samuel Monson M. D.
Address 11 E. Chase St. Date signed

X

G47029

505767

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH √137a

G47029 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 1

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3212 Baynore Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles L Wood.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Ida R.

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 9-4-62.

8. AGE: Years 84 | Months 3 | Days 26 27 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Robert B. Wood
13. Birthplace Va

MOTHER
14. Maiden Name Martha Hollingsworth
15. Birthplace Ohio

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 2/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Charles C Powell
(b) Address 2427 Edmondson Ave

19 (a) Huntington Williamson
(Date received by local registrar) DEC 31 1946

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 31 1946, at 1.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 4. 1946 to Dec. 31 1946 and that I last saw him alive on 31 Dec. 1946 1:30 P.m.

Immediate cause of death Coronic failure & anemia — Duration 14 days

Due to Post-operative atelectasis — 14 days

Due to

Other Conditions Benign prostatic hypertrophy — 2 yrs.

(Include pregnancy within 3 months of death)

Date of operation Dec. 16 46

Major findings of operation: Benign P.H.

of autopsy No

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Willard O. Goodwin M. D.

Address Johns Hopkins Hospital Date signed 3 Jan 1947

G47030

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G47030 Registered No.

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. Fill correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE AND JOHN
(c) Hospital or institution:
HOSPITAL FOR THE WOMEN OF MARYLAND

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 22 YRS

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MARYLAND County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3209 LEVERTON AVE
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** MADELINE LOUISE SCHUNK

3 (b) If veteran, name war —

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | M |

6 (b) Name of husband or wife ROBERT JOSEPH SCHUNK
6 (c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr.) July 19, 1924

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 22 | 5 | 9 | ____ hr. ____ min. |

9. Birthplace BALTIMORE — MARYLAND
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business HOME

FATHER
12. Name JOSEPH ALLOYSIUS BELFE
13. Birthplace PHILADELPHIA, PA

MOTHER
14. Maiden Name NELLIE ADONIA HALL
15. Birthplace CRISFIELD MD

16 (a) Informant JOSEPH ROBERT SCHUNK
(b) Address 3209 LEVERTON AVE

17 (a) Burial (b) Date thereof Jan 2 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR RD.

18 (a) Funeral director John A. Moran
(b) Address 3600 E Baltimore St

19 (a) ____ (b) ____
(Date received by registrar) (Registrar)

DEC 31 1946 Huntington Hillsboro, MD

## MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Dec 1946, at 11:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 27 Dec 1946, to 28 Dec 1946, and that I last saw h.R.R. alive on 28 Dec 1946

| Immediate cause of death | Duration |
|---|---|
| RESPIRATORY FAILURE | |
| Due to Acidosis (Coma) | 2 DAYS |
| Due to DIABETES MELLITUS | 8 YRS |
| Other Conditions GASTROENTERITIS | 3 DAYS |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fred B. Agre, Jr M. D.
Address Womans Hospital Date signed 29 Dec 46

X

G47031 OOH F55713

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 52B

G47031 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 47
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 644 Fraser Pl.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Clarence Woods

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 5 1942

8. AGE: Years 4 Months 4 Days 13 If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Louis Cousins
13. Birthplace Md

MOTHER 14. Maiden Name Louise Williams
15. Birthplace

16 (a) Informant Louise Williams
(b) Address 644 Fraser Pl

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) Dec 31 1946

(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director A. Halstead Hull
(b) Address 916 Druid Hill Ave

19 (a) Registrar (b) Date received by Registrar DEC 31 1946

Hunter for Williams, M.D.

S-190

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 28 1946, at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 11 1946 to Dec 28 1946, and that I last saw him alive on Dec 28 1946.

Immediate cause of death Peritonitis;
Sarcoma of Bladder

| Duration |
|---|
| |
| |
| |
| |

Due to Post-operative drainage

Due to Poor physical condition

Other Conditions Dehydration

(Include pregnancy within 3 months of death)

Date of operation Nov 11 & Dec 26 1946

Major findings of operation: Tumor of ureter bladder, removed

of autopsy: Peritonitis; bladder tumor

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. E. MacCurdy M.D.

Address University Hosp Date signed 12-31-46

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

G47032

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

G47032 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2841 Green Mount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2841 Green Mount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Edward R. Coggins Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Wallzta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 5 | 14 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Tallyman

FATHER 12. Name Edward R. Coggins
13. Birthplace Md.

MOTHER 14. Maiden Name Josephine M. Schweitzer
15. Birthplace Md.

16 (a) Informant Richard K. Coggins
(b) Address 3717 Belvedere Ave

17 (a) Burial (b) Date thereof 1/1/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 DEC 31 1946 (b)
(Date rec'd by registrar)

Thurlington Williams Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 30th 1946 at 6 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 14th. 1946 to 12/30 1946.
and that I last saw him alive on 12/17 1946.

Immediate cause of death: Chronic Parenchymatous Nephritis — Duration: unknown

Due to: ---------

Due to:

Other Conditions: Chronic Prostititis — unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lee W Margaretten M.D.
Address 401 E. 25th. St. Date signed 12/31/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1
G47033

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 1318

G47033
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1309 E.Lafayette Ave
(c) Hospital or institution: 9-9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 E.Lafayette Avenue
(Rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Ellen Lawlor

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: James C.Lawlor
6 (c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1884

8. AGE: Years 62 | Months 10 | Days 16 | If less than one day: ########## hr. ____ min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John McAuliffe
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Sheehan
15. Birthplace Ireland

16 (a) Informant Mrs John J. Lawlor (Son)
(b) Address 1744 Harford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 2, 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) DEC 31 1946 (b) ____
(Date received by Registrar) Huntington Williams, Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 30 1946, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1943 to Dec 30 1946 and that I last saw her alive on Dec 28 1946.

Immediate cause of death: Pneumonia - bronchial — Duration: 3 days
Due to: ____
Due to: ____
Other Conditions: Chronic nephritis — 10 years
Uremia - 6 months
(Include pregnancy within 3 months of death)
Date of operation: ____
Major findings of operation: ____
of autopsy: ____

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: ____
(b) Date of occurrence: ____ at ____ M
(c) Where did injury occur? ____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____
(Specify type of place)
(e) Means of injury: ____

23. Signature: Alan Bernstein, M. D.
Address 1109 N Calvert St Date signed 1/7/30/47

X

G47034

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 1463

G47034 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2018 McCulloh
(c) Hospital or institution: 14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2018 McCulloh (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Richard Randolph Hicks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M. | C | Widower |

6 (b) Name of husband or wife Naomi
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 7 | 19 | hr. min. |

9. Birthplace Oxford N. C. (Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Dorothy Matthews
(b) Address 2525 Woodbrook Ave

17 (a) Burial (b) Date thereof 1-2-47 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Mt. Calvary
Location A-A-60.

18 (a) Funeral director Jesse W. Redden
(b) Address 456 W. Biddle St.

19 (a) (Date rec'd by registrar) (b) [illegible]

DEC 31 1946

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec. 29 1946, at 5:30 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 9-4 1926 to 12-29 1946, and that I last saw h[illegible] alive on 12-29 1946.

Immediate cause of death Carcinoma of Stomach — Duration 3 Yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23.** Signature B. B. Hatch
Address 1725 Eutaw Date signed 12/30/46

X

G47035

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 181

Registered No. G47035

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 Vincent Ct. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Fred Amos

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | |

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1922

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 24 | | | ....hr. ....min. |

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Will Amos
13. Birthplace N. C.

MOTHER
14. Maiden Name -
15. Birthplace -

16 (a) Informant Rev. L. P. Amos.
(b) Address 1321 N. Stockton St

17 (a).....(Burial, cremation, or removal) (b) Date thereof 2-2-47 (month) (day) (year)
(c) Cemetery or crematory Durham, N. C
Location N. C.

18 (a) Funeral director Geo. W. Kelson
(b) Address 803 Presstman St.

19 (a) DEC 31 1946 (Date rec'd by registrar) Huntington Williams Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/31 1946 at 1 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia, due to extensive second and third-degree burns, involving about 80% of body surface

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/22/46 at 6:30 A.M. 16/1
(b) Where did injury occur? 1200 Winchester Maryland Dairy
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(Gasoline explosion)
(d) Means of injury Clothing caught fire.

23. Signature Hugh F. Mehrle M.D.
Medical Examiner.
Date signed 12-31-46

G47036

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

G47036 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 11-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1228 Madison Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Florence Lee Woodland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Robert C. Woodland
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) — 1897

8. AGE: Years 49 | Months | Days — | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Lee
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Robert C. Woodland
(b) Address 1228 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 1 - 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James A. Lacy
(b) Address 1143 W. Fielder St.

19 (a) DEC 31 1946 (Date received by registrar) Huntington Williams, M.D. (Signature of registrar)

VS 184

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** December 28 1946, at 4 45 M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 12-26-1946, to 12-28-1946, and that I last saw her alive on 12-28-1946.

| Immediate cause of death | Duration |
|---|---|
| Subarachnoid Hemorrhage | 7 |
| Due to Hypertension | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23.** Signature [signature] M.D.
Address Provident Hosp. Date signed 12/30/46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47037

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

137a

Registered No. G47037

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Edmondson & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Worcester
(c) City or town Whaleyville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Lewis

3 (b) If veteran, name war: none
3 (c) Social Security Account No. None

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | white | married |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 11 | 29 | hr. min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name James Lewis
13. Birthplace Md.

MOTHER
14. Maiden Name Ellen Collins
15. Birthplace Md.

16 (a) Informant John Lewis
(b) Address Berlin, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/47 (month) (day) (year)
(c) Cemetery or crematory
Location Whaleyville, Md.

18 (a) Funeral director Mrs. M. Pasha Watson
(b) Address Selbyville, Delaware

19 (a) (Date rec'd by registrar) (b)

DEC 31 1946

Filing for Williamsville, Md.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 30 1946, at 3:25 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1946, to Dec. 1946, and that I last saw him alive on Dec 30 1946.

Immediate cause of death Acute cardiac failure — Duration

Due to Arteriosclerosis

Due to Pat - agenital Kenneth post-Dilation

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation Dec 30, 1946

Major findings of operation: Biopsy

Surgical pathological report

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. E. McAuley M. D.
Address University Hosp. Date signed 1/12/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47038

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1946

G47038 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5304 St.Georges Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-10
(e) Length of stay in Baltimore (yrs., mos., or days) 24 years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5304 St. Georges Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MINNIE M. RICH

3 (b) If veteran, name war
3 (c) Social Security Account No. No

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Lemuel J. Rich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1869

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 8 | 17 | hr. min. |

9. Birthplace Gorham, Maine (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Clark
13. Birthplace Not known

MOTHER
14. Maiden Name Not Known
15. Birthplace " "

16 (a) Informant Mr. Williwm R. Rich
(b) Address 5304 St. Georges Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 1,1947 (month) (day) (year)
(c) Cemetery or crematory Gorham
Location Main St. ,Gorham, Maine

18 (a) Funeral director William J.Tickner & Sons
(b) Address North & Penna. Aves

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS DEC 31 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 1946, at 7A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 3 1936, to Dec 29 1946, and that I last saw h- alive on Dec 29 1946.

| Immediate cause of death | Duration |
|---|---|
| Arteriosclerosis | 1936 |
| Chron Myocarditis | 1936 |
| Due to Cerebral Hemorrhage | 1946 |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? N While at work? (Specify type of place)
(e) Means of injury

23. Signature E. W. Bishop
Address 583 Shenda a Date signed Dec 30 M. D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47039

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

G47039 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4010 Penhurst Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4010 Penhurst Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ANNA MARY FRANK

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife John Carl Frank
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 30, 1863

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 11 | 0 | hr. min. |

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jacob Kratz
13. Birthplace Unknown

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Mr. John Carl Frank
(b) Address 3308 Elgin Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/1/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 31 1946 (Date received by Registrar) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION** 30 Dh

20. DATE OF DEATH Dec. (12, 24) 1946, at 2:15a M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/ j / 1944 to 12/ 3 / 1946 and that I last saw h[illegible] alive on 12/ 28 1946

| Immediate cause of death | Duration |
|---|---|
| Hemiplegia & Coma | 10 days |
| Due to | |
| Due to High Blood Pressure & Hardening of Arteries | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: no

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature A. A. Hearn M. D.
Address 7901 Forrest Ave. Date signed 12/28/46

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47040 / 937 — Registered No. G47040

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2430 Brambleton Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2430 Brambleton Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** EMMA LEE BROWN

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | no |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widow |

6 (b) Name of husband or wife Edward Marion Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 3 | 9 | hr. min. |

9. Birthplace Forest Hill, Md.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Thomas E. Smithson
13. Birthplace Md.

MOTHER
14. Maiden Name Mary J. Phelps
15. Birthplace Md.

16 (a) Informant Mr. Marion L. Brown
(b) Address 2013 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/47 (month) (day) (year)
(c) Cemetery or crematory Centre Forest HILL
Location Maryland

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b)

VS 150 DEC 31 1946

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 30, 1946, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-26 1946 to 12-30 1946 and that I last saw her alive on 12-29 1946.

| Immediate cause of death | Duration |
|---|---|
| myocarditis -from history | 2 yrs. |
| Due to acute dilitation | 1 day |
| Due to advanced arterio-sclerosis | ? |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 2220 Garrison Blvd. Date signed Dec 31/46

X

G47011 BALTIMORE CITY HEALTH DEPARTMENT G47011

# CERTIFICATE OF DEATH

Registered No. 1250

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 142 N. Lakewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Thomas W. Carney (Thomas W. Carney)

3 (b) If veteran, name war --

3 (c) Social Security Account No. 216-01-9209

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | separated |

6 (b) Name of husband or wife Anna Carney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1913

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 33 | 1 | 8 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John J. Carney
13. Birthplace England

MOTHER
14. Maiden Name Margaret McHale
15. Birthplace Ireland

16 (a) Informant Mrs. Anne Casey
(b) Address 8 N. Rose St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 2, 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director Philip J. Sterling Sons
(b) Address 2024 Orleans St.

19 (a) (b)
(Date rec'd by registrar) (Registrar's signature)

DEC 31 1946

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/29 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/25 1946 to 12/29 1946 and that I last saw h[im] alive on 12/29 1946.

Immediate cause of death Cardio-respiratory failure — Interval

Due to pneumonia

Due to multiple cutaneous abscesses

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: multiple cutaneous abscesses

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julius Kaminsky M. D.
Address W. Jos. Street Date signed

G47012

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

Registered No. G47012

correct ago is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 30 N Linwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 30 N. Linwood Ave (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

**3 (a) FULL NAME** Frederick John Rau

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | widowed. |

6 (b) Name of husband or wife Minnie E Lingfelt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 5 | 6 | hr. min. |

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Gas + Electric Co.

FATHER
12. Name Louis Rau
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Theresa Kolb
15. Birthplace Md.

16 (a) Informant Dora Bittinger
(b) Address 30 N Linwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 2-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Taylor Ave

18 (a) Funeral director John A Miller
(b) Address 2034 Jefferson St.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 31 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 1946, at 5 15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 23 1946, to Dec 29 1946, and that I last saw him alive on Dec 29 1946.

| Immediate cause of death | Duration |
|---|---|
| Terminal pneumonia | 2 days |
| Due to Cerebral apoplexy | 21 days |
| Due to generalized arteriosclerosis | |
| Other Conditions Senility | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James E. Darby Jr. M. D.
Address 2936 E. Baltimore St. Date signed 12/29/46

24 X

506877
G47013

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 61

Registered No. G47013

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2500 E. Frankford Ave
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2500 E. Frankford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Hedwig Huber
3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Otto Huber
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) 7-5-86

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 5 | 24 | hr. min. |

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Franz Miller
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31-46 (month) (day) (year)
(c) Cemetery or crematory Balto. Comm. Location North Ave. Gay St.

18 (a) Funeral director John L. Miller
(b) Address 2334 Jefferson St.

19 (a) Dec 31 1946 (Date received by registrar) (b) Lumington Williams, M.D. Registrar

VS 150

**MEDICAL CERTIFICATION** 50

20. DATE OF DEATH Dec 29, 1946, at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 25 1946 to Dec 29 1946 and that I last saw h alive on Dec 29 1946.

| Immediate cause of death | Duration |
|---|---|
| Congestive Heart Failure | |
| Due to Myocardial infarction | |
| Due to Hypertensive + Arteriosclerotic Heart Disease + Coronary thrombosis | |
| Other Conditions Diabetes mellitus, mild | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Robert C. Austrian M. D.
Address The Johns Hopkins Hosp. Date signed Dec 31 46

931

G47044

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 195E

Registered No. G47044

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4800 Orville Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ADDISON B. HARRISON

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-10-3900

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Francis Harrison
6 (c) If alive, give age 25 years

7. Birth date of deceased (mo., day, yr.) May 2, 1905

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 41 | 7 | 28 | hr. min. |

9. Birthplace Va
(Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Edw. Harrison
13. Birthplace Va

MOTHER
14. Maiden Name Nellie Fry
15. Birthplace Va

16 (a) Informant Francis Harrison
(b) Address 4800 Orville Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3 47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Md

18 (a) Funeral director M R Eichelberger & Son
(b) Address Frederick Md

19. (a) DEC 31 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 30, 1946, at 9.40 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull.
Laceration of brain.
Intracranial hemorrhage

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-30-46 at 9.30 P.M. Rivoli
(b) Where did injury occur? 400 E. Balto. St. Theatre
(c) Did injury occur at home, on farm, industrial place, in public places? Public While at work? Yes
(d) Means of injury struck by falling object

23. Signature Geo. G. McNeil M.D.
Medical Examiner.
Date signed 12-30-46

4/1

X

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47015

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 93D

Registered No. G47015

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4301 Wiltshire Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 76
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4301 Wiltshire Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H Bentz

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mamie G. Bentz
6 (c) If alive, give age 62 years
7. Birth date of deceased (mo., day, yr.) July 22 - 1871
8. AGE: Years 75 | Months 5 | Days 7 | If less than one day ____ hr. ____ min.
9. Birthplace Frederick Md (Town, county, and state)
10. Usual Occupation Restaurant
11. Industry or business Retired

FATHER
12. Name Henry Bentz
13. Birthplace Md

MOTHER
14. Maiden Name Catherine De Grange
15. Birthplace Md

16 (a) Informant Mamie Bentz
(b) Address 4301 Wiltshire Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 2/1947 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Frederick Md
Location
18 (a) Funeral director Ullrich Funeral Home
(b) Address 2098 Orleans St
19 (a) (Date rec'd by registrar) (b) Clayton Williams, M.D. registrar

VS 150 DEC 31 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1946, at 3.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1946 to Dec 29 1946 and that I last saw h alive on Dec 29 1946.

| | Duration |
|---|---|
| Immediate cause of death: Myocardial Failure | 2 hrs. |
| Due to: Chronic Myocarditis | 10 years |
| Due to: | |
| Other Conditions: Chronic Bronchitis | 20 years |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: none

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Lachman M. D.
Address 2722 Ellwood Ave Date signed Dec 30, 1946

X

G47016 BALTIMORE CITY HEALTH DEPARTMENT G47016

# CERTIFICATE OF DEATH

Registered No. 944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 710 Collington Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 710 Collington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Jacob Levin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | married |

6 (b) Name of husband or wife Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Russia

MOTHER
14. Maiden Name Helen
15. Birthplace Russia

16 (a) Informant Rose Levin
(b) Address 710 Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-46 (month) (day) (year)
(c) Cemetery or crematory
Location Woodlawn Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 407 E Balto St

19 DEC 31 1946 Registered

Huntington-Holbrook, M.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/30/46, 1946, at 5a M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5 1940 to 12/30 1946 and that I last saw him alive on 12/29 1946.

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | |
| Due to | |
| Due to | |
| Other Conditions Chronic Nephritis | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. C. Hurdle M. D.
Address 825 Eutaw Date signed 12/31/46

VS 150

G47047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131a

G47047
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 317S. Chester Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 317 S. Chester Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Broczkowski ( Burke )

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28 1880

8. AGE: Years 66 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Broczkowski
13. Birthplace Poland

MOTHER
14. Maiden Name Julia Zdrojeska
15. Birthplace Poland

16 (a) Informant Mrs. Frances Broczkowski
(b) Address 317 S Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-2-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary (em
Location Baltimore County

18 (a) Funeral director John M. Welsh
(b) Address 401 E. Chester Street

19 (a) Filed DEC 31 1946 (b) Registrar Hampton Williams

MEDICAL CERTIFICATION 4.30

20. DATE OF DEATH Dec 29 1946, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1946 to Dec 29 1946 and that I last saw h[illegible] alive on Dec 28 46

Immediate cause of death: Cardio vascular renal disease.

Duration: 6 mo +

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leon J. Lippy M. D.
Address 1131 Cathedral St Date signed 12/30/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G47018

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1939

G47018 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1110 N. Wolfe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1110 N. Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Foster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John Foster

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861?

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace Mcherrin Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name George Peters

13. Birthplace Va

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Georgia A. Watkins

(b) Address 1110 N. Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 1 1940 (month) (day) (year)

(c) Cemetery or crematory Mcherrin

Location Virginia

(a) Funeral director Robert E. Williams

(b) Address 1515 McElderry St

(a) Filed by registrar (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1939 at 5:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1939 to Dec 30 1939 and that I last saw h alive on Dec 2 1939

Immediate cause of death: Congestive Heart Failure — Duration

Due to: Hypertension Cardio Vascular Disease

Due to: Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature T. J. Adams M.D.

Address 1222 N. Carlton Date signed 1-2-40

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G47049

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 194a

G47049 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1902 Ramsay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Anthony Alexander
3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Elsie May Hurst
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 8, 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 9 | 23 | hr. min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John T. Alexander
13. Birthplace Md.

MOTHER
14. Maiden Name Mary C. Hobbs
15. Birthplace Md.

16 (a) Informant Mrs Elsie M. Alexander
(b) Address 1902 Ramsay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 3, 1947 (month) (day) (year)
(c) Cemetery or crematory Maryland Memorial Park
Location Parkville, Md.

18 (a) Funeral director C. Harry Weer
(b) Address Lyndhurst, Md.

19 (a) Filed by registrar [illegible] (b) [illegible] Williams, M.D. Registrar

JAN 3 1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 31, 1946, at 3:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 24 1946, to Dec 31 1946, and that I last saw h[illegible] alive on Dec 31 1946.

Immediate cause of death Myocardial Infarction — Duration

Due to Coronary Thrombosis

Due to Coronary Artery Disease

Other Conditions Bilateral Basilar Bronchopneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Gutzmer M. D.
Address 3706 Rosedale Rd Date signed 1/2/31/47

G47050

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH √ 120

G47050 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1517 McCulloh St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Bailey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Colored | married |

6 (b) Name of husband or wife Fannie C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1, 1912

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 34 | 10 | 28 | hr. min. |

9. Birthplace Cape Charles, Va
(Town, county, and state)
10. Usual Occupation Presser
11. Industry or business Tailor

FATHER
12. Name John Bailey
13. Birthplace Virginia

MOTHER
14. Maiden Name Mollie Spady
15. Birthplace Cape Charles, Va

16 (a) Informant Mrs. Fannie C. Bailey
(b) Address 1517 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 31, 1946 (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Cape Charles, Va
Funeral director Thos. A. Hallen
(b) Address 1631 Druid Hill Ave.
(Signature of Registrar) Williams, M.D. Registrar

DEC 31 1946

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec 29 1946, at 6 A M

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute nephritis
Dilatation of heart
Due to Acute pulmonary edema

Other Conditions
(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 12-30-46

VS 151

Please write the causes of death clearly and legibly. Physicians: please write this especially important.

G47051 BALTIMORE CITY HEALTH DEPARTMENT G47054
Registered No.

# CERTIFICATE OF DEATH 1952

1. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 109 N. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John May

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 27, 1894

8. AGE: Years 52 | Months 2 | Days 2 | If less than one day: hr. min.

9. Birthplace Fall River, Mass (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name May
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-2-47 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Bait Md

18 (a) Funeral director George A Tarbey
(b) [illegible] Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/29 1946 at 11 35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/29 1946 to 12/29 1946, and that I last saw h. alive on 12/29 1946.

| Immediate cause of death | Duration |
|---|---|
| Terminal Broncho-pneumonia | |
| Due to Cardiac Failure | |
| Due to Rheumatic Heart Disease | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at A.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward H. Southwick M. D.
Address Franklin Square Hosp Date signed 12/30/46

G47052

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

124a

G47052
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Milford
(If outside city or town limits, write RURAL and give town)
(d) Street No. Fairview Ave at Liberty Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cyril J Stamper

3 (b) If veteran, name war

3 (c) Social Security Account No. 093-07-4335

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | married |

6 (b) Name of husband or wife Helen G Stamper
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Sept 27 1907

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 44 ~~45~~ | 3 | 3 | hr. min. |

9. Birthplace Carlisle England
(Town, county, and state)
10. Usual Occupation Chief Radio Inspector
11. Industry or business Radio Marine Corp of

FATHER
12. Name John Frederick Stamper
13. Birthplace Carlisle, England

MOTHER
14. Maiden Name Kate Bennett
15. Birthplace England

16 (a) Informant Mrs Helen G Stamper
(b) Address Fairview Ave Milford

17 (a) Cremation (b) Date thereof Jan 3 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Baltimore Md.

18 (a) Funeral director E W Pumphrey
(b) Address 4510 Liberty Hgts Ave

JAN 31 1947
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 1946, at 4 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 28 1946 to Dec. 30 1946, and that I last saw h alive on Dec. 30 1946

Immediate cause of death Acute Peripheral Circulatory Failure — Duration

Due to Generalized Convulsions

Due to Uremia Anemia & Chronic Glomerulonephritis

Other Conditions Acute hepatitis

(Include pregnancy within 3 months of death)

Date of operation Dec. 28, 1946

Major findings of operation: Fatty infiltration of liver; tender inflamed Gall Bladder

of autopsy: fatty infiltration of liver & Cirrhosis

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. E. McCord M. D.

Address University Hospital Date signed 1/31/47

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47053 Registered No. G47053

G47053 836

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4304 Belair Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4304 Belair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MYRTLE ROSE MORGAN

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| NO | NONE |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife George Morgan
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 2 | 2 | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William J. Schwarzenberg
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Lillian Myrtle
15. Birthplace Frederick, Maryland

16 (a) Informant Mr. George Morgan
(b) Address 4304 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1- -47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Maryland

18 (a) Filed DEC 31 1946
(b) Address NORTH AVE. & BROADWAY

19 (a) Received DEC 30 1946 (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 29 1946, at 8 PM M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to Dec. 29 1946.
and that I last saw him alive on Dec. 27 1946.

Immediate cause of death Cerebral thrombosis
Due to Malignant Hypertension
Due to
Other Conditions Deformed left foot from old accident Feb. 1918
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [signature]
Address 3408 Edmondson Ave Date signed 12/30/46 M. D.

VS 150

X

Every item of information should be carefully supplied. The correction especially important. Physicians: please write the causes of death clearly and legibly.

G47054

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1248

G47054 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 618 S Belnord Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 618 S Belnord (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Raymond W Rollins

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Hilda Copperwaite

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8 1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 7 | 22 | hr. min. |

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Despatcher

11. Industry or business American Can Co

FATHER 12. Name William Rollins
13. Birthplace Md

MOTHER 14. Maiden Name Mary Young
15. Birthplace Md

16 (a) Informant Hilda Rollins
(b) Address 618 S Belnord Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 2 1947 (month) (day) (year)

(c) Cemetery or crematory Mt Lebanon Mem
Location Balto Co Md

18 (a) Funeral director Welsh Funeral Home
(b) 1008 Orleans St

DEC 31 1946 (a) (b)
(Date rec'd by registrar) Registrar

DEC 31 1946

Huntington Williams, M.D.

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Dec 30 1946 at 6 40 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec. 24 1946 to Dec. 30 1946 and that I last saw h[im] alive on Dec. 29 1946

| Immediate cause of death | Duration |
|---|---|
| Hypertension - Coron - Thrombosis | Duration |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23. Signature** Landis Townsworth M. D.

Address 3529 Eastern ave Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47055

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH √ 931

G47055 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Forest Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (Color)
(b) City or town Lorraine Park (If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 Forest Hill (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minetta C Chapman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Robert

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Feb. 11-1872

8. AGE: Years 74 | Months 8 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Leonard Nicholl
13. Birthplace England

MOTHER
14. Maiden Name Lunt
15. Birthplace England

16 (a) Informant Robert Chapman
(b) Address 1317 Forest Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 31 Dec 46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn Road

18 (a) Funeral director [illegible]
(b) Address [illegible]

19 (a) 1948 (b) [illegible]
(Filed by registrar) Registrar

VS 189

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/28/ 1946, at 4:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1936, to Dec 27 1946, and that I last saw h[illegible] alive on Dec 27 1946

| | Duration |
|---|---|
| Immediate cause of death Coronary Occlusion | ? |
| Due to Arteriosclerotic Cardio Vascular Disease | ? |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earle A Rostring M. D.
Address 326 W Lombard St Date signed 12/30/46

Forget age is especially important. Physicians: please write the causes of death clearly and legibly.

G47056

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47056 Registered No. 1316

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3704 Dolfield Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Hilda Fruchtbaum

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | |

6 (b) Name of husband or wife Dr David P. F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1911

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 35 | 9 | 11 | hr. min. |

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business House Wife

FATHER
12. Name Phillip Aaron
13. Birthplace Europe

MOTHER
14. Maiden Name Alice Fagelman
15. Birthplace Europe

16 (a) Informant Dr David P. Fruchtbaum
(b) Address 3704 Dolfield Blvd

17 (a) Burial (b) Date thereof Jan 1 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Beth Tefilah Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 112-4-26 W Madison

1947 JAN 1 (b)
(Registrar) Registered

Thurlington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-31 1946, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12 1946 to 12-31 1946, and that I last saw her alive on 12-31 1946.

| Immediate cause of death | Duration |
|---|---|
| Cardiac standstill | |
| Due to Cardiac Failure | |
| Terminal Uremia | |
| Due to Malignant Hypertension | |
| Hypertensive Cardiovascular Renal Disease. | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Shallenberger M.D.
Address University Hospital Date signed 1-3-47

G47057

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 92 B

G47057 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St. Baltimore
(c) Hospital or institution: Sisters of the Poor 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs. 12mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** Nina Cox

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | widowed |

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 7 | 25 | hr. min. |

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name Christian G. ?
13. Birthplace ?

MOTHER
14. Maiden Name Eliz. Smith
15. Birthplace ?

16 (a) Informant Sisters of the Poor
(b) Address 1200 Valley Blvd city.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 2. 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 Biddle St E.

19 (a) 1 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 – 1946, at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 – 1946, to Dec 30 1946, and that I last saw her alive on Dec 30 1946.

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | 1 day. |
| Due to Mitral Stenosis | 6 yrs |
| Due to | |
| Other Conditions Arterio-Sclerosis | 5 yrs |

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall
Address 1631 E North Av Date signed 12/31/46 M. D.

VS 3

G47058 BALTIMORE CITY HEALTH DEPARTMENT G47058
Registered No.

# CERTIFICATE OF DEATH 1937

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WRITE PLAINLY, WITH UNFADING INK.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 116 E. Melrose Ave.
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County ----------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 E. Melrose Ave.
(If rural give location)
(e) Citizen of foreign country? ---------- (Yes or No)
If yes, name country ----------

**3 (a) FULL NAME** Percy Thayer Blogg

3 (b) If veteran, name war ----------
3 (c) Social Security Account No. ----------

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of wife Isabel Ogier
6 (c) If alive, give age ---years

7. Birth date of deceased (mo., day, yr.) Unknown

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| About 70 | --- | --- | --- hr. --- min. |

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Proprietor of Alpha
11. Industry or business Photo Engraving Co.

MOTHER / FATHER
12. Name Edward N. S. Blogg
13. Birthplace Germany
14. Maiden Name Charlotte Thayer
15. Birthplace Virginia

16 (a) Informant Miss Eva M. W. Blogg
(b) Address 726 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/47 (month) (day) (year)
(c) Cemetery Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director H. A. Meare & Son
(b) Address 805 N. Calvert St.

19 (a) (Date received by registrar) Huntington Williams, M.D.

JAN 1 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH DEC. 31 1946, at 8:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from APR 1946, to DEC 1946, and that I last saw him alive on DEC 30 1946.

| Immediate cause of death | Duration |
|---|---|
| ARTERIOSCLEROTIC HEART DISEASE | 2 YRS? |
| Due to AURICULAR FIBRILLATION | 1 YEAR? |
| Due to PULMONARY EMBOLISM REPEATED 5 MOS. | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph J. Hills M. D.
Address 18 E Eager St Date signed Jan 1, 1947

Baltimore Md X

VS 150

G47059 (1)

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G47059

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1420 N. Charles St. (Sammis Home).
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Richard Wilbert Cromwell

3 (b) If veteran, name war: U.S.

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 7 1900

8. AGE: Years 46 | Months 10 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business U.S. Merchant Marines

FATHER
12. Name Dr. Martin John Cromwell
13. Birthplace Balto Md

MOTHER
14. Maiden Name Bettie Jenkins
15. Birthplace Balto Md

16 (a) Informant Mrs. Jeanette Jannier
(b) Address 3405 Gelenway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 2 1947 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Bon Secours Cathedral
Location Balto Md

18 (a) Funeral director Henry J. Jenkins & Son
(b) Address McCulloh & Orchard Sts.

19 (a) 1947 (Date rec'd by registrar) (b) for William ... Registrar

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 31, 1946 at M

21. I certify that I took charge of the remains described above, held an inquiring thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-vascular disease.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 12-31-46

X

G47060

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

✓ G47060 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3305 Dolfield Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 3305 Dolfield ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Zerdin

3 (b) If veteran, give war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widower

6 (b) Name of husband or wife Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name unknown
13. Birthplace Russia

MOTHER 14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Mrs Albert Schneider
(b) Address 3305 Dolfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-1-47 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel
Location Southern Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 E Balto St

19 (a) 1947 (Date rec'd by reg.) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31st 1946 at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Dec 31 1946 and that I last saw h[illegible] alive on Dec 31 1946

Immediate cause of death: Pulmonary Edema — Duration 2 hrs
Due to: Left Ventricular Failure — 6 hrs
Due to: Hypertensive Cardio Vasc Disease — 7
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. T. Lissuetz M. D.
Address 3710 Liberty Hts Ave Date signed Dec 31st

VS 150

NOTE.—Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G47051

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 43

G47051 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Edmondson & Greene Ave
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 dy
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto.
(c) City or town Rusticatown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roy Krause

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 4 1909

8. AGE: Years 37 | Months 4 | Days 27 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Employed Suburban

11. Industry or business Propane Gas Co

FATHER 12. Name George Hradec

13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth Opel

15. Birthplace Md.

16 (a) Informant Mrs Evelyn Krause

(b) Address Rusticatown

17 (a) Burial (b) Date thereof Jan 3 47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory All Saints

Location Balto Co.

18 (a) Funeral director J. F. Eline Sons

(b) Address Rusticatown

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

JAN 1 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/31 1946 at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/19 1946 to 12/31 1946 and that I last saw h[illegible] alive on 12/31 1946

| Immediate cause of death | Duration |
|---|---|
| Medullary failure | |
| Due to Lomba Meningitis | |
| Due to Torula | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Torula Meningitis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph F. Price

Address Louis Hospital Date signed 1/1/47

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47062

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X ✓G47062 Registered No. 102

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Eaton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 Smith's Lane (28)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Bertha Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Albert J. Smith

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Jan 22 1892

8. AGE: Years 54 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Private Family

FATHER
12. Name [redacted]
13. Birthplace Howard Co Md.

MOTHER
14. Maiden Name Elizabeth Eckles
15. Birthplace Howard Co Md

16 (a) Informant Albert J. Smith.
(b) Address 3 Smith Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 2/47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Rd City

18 (a) Funeral director Edgar Mac Nabb
(b) Address Catonsville Md

19 (a) 1947 (Date rec'd by registrar) (b) [illegible] Registrar

**MEDICAL CERTIFICATION** 50

20. DATE OF DEATH 12/31 1946 at 2 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

| Immediate cause of death | Duration |
|---|---|
| Cardiac Failure | |
| Due to Hypertension | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clifton Smith Jones M. D.
Address [illegible] Date signed 1/3/47

VS 150

cedent age is especially important. Physicians: please write the causes of death clearly and legibly.

G47063

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47063
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4021 GREENMOUNT AVE.
(c) Hospital or institution:
NONE
(d) Length of stay in hospital or inst. (yrs., mos., or days) NONE
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4021 GREENMOUNT AVE
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** EDWARD MAGUIRE.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife OCT. 25-1866
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 2 | 5 | hr. min. |

9. Birthplace Phila Pa.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Patrick Maguire
13. Birthplace Dalland

MOTHER
14. Maiden Name Mary Dunphy
15. Birthplace Ireland.

16 (a) Informant Edith J Maguire
(b) Address 4021 Greenmount Ave

17 (a) Burial (b) Date thereof Jan. 2 '47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Nat. Cath.
Location Old Frederick Rd.

18 (a) Funeral director John A. McCann
(b) Address 3040 E. Balto. St.

19 (a) Huntington Williams, M.D. Registrar
(Date received by registrar)

JAN 1 1947

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** DECEMBER 30 1946 at 1030P M

21. I certify that death occurred on the date above stated; that I attended deceased from SEPTEMBER 1.46 to DEC. 30 1946, and that I last saw h 1m alive on DEC. 30 1946

| Immediate cause of death | Duration |
|---|---|
| CHRONIC MYOCARDITIS. SEPT 1 | 1946 |
| Due to ARTERIOR SCLEROSIS. | 1946 |
| Due to MULTIPLE SCLEROSIS. | 1944. |

Other Conditions NONE
(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: NONE
of autopsy: NONE

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward J Maguire
3013 ST PAUL STREET DECEMBER 31, 1946
Address Date signed

X

N correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47064

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

V 105

Registered No. G47064

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 310 S. Wolf St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) No
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 310 S. Wolf St
(If rural give road)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Sadowski

3 (b) If veteran, name war No | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/25/1924

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 22 | 11 | 5 | hr. min. |

9. Birthplace Balto - City
(Town, county, and state)
10. Usual Occupation None
11. Industry or business Home work

FATHER
12. Name Benjamin Sadowski
13. Birthplace Australia

MOTHER
14. Maiden Name Gratowska
15. Birthplace Balto City -

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 1-2-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore City -
18 (a) Funeral director Odell Funeral Home Inc
(b) Address 403 E - 26th St
19 (a) (b)
(Date rec'd by registrar) (Registrar)

VS JAN 2 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1946, at 10:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19..., to 19..., and that I last saw h... alive on 19...

| Immediate cause of death | Duration |
|---|---|
| Acute edema of glottis | prev |
| Due to? Angioneurotic edema | |
| ? Diphtheria | |
| Due to | |
| Other Conditions PULMONARY EDEMA | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Birdsall P Cole M. D.
Johns Hopkins Hosp Date signed 1-1-47
Howard J. Madden, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47065

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

157 D

G47065 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Union Hos
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Howard
(c) City or town Marriottsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ray Hope

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 2 | 14 | 15 hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name unknown
13. Birthplace ?

MOTHER
14. Maiden Name Ozella Hope
15. Birthplace WVa

16 (a) Informant Ozella Hope
(b) Address Marriottsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-47 (month) (day) (year)
(c) Cemetery or crematory Marriottsville Md
Location Marriottsville, Md

18 (a) Funeral director H. C. Hughes Thorn
(b) Address Ellicott City Md.

19 (a) (b)
(Signature of registrar)

JAN 2 1947 Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/31 1946 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-23 1946 to 12-31 1946, and that I last saw h[illegible] alive on 12-31 1946

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Central Defect | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Harley, M.D.
Address Univ. Hosp. Date signed 1/2/47

X

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G47066

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47066 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2526 Calvert St.
(c) Hospital or institution:
None.
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County Hanover County
(c) City or town Beaverdam,
(If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D. #2, Box. 61.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A. Taylor

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Hattie B Taylor.
Dead
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1876

8. AGE: Years 70 | Months 11 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Hanover County, Virginia
(Town, county, and state)

10. Usual Occupation Farmer.
11. Industry or business "

FATHER
12. Name Farley B. Taylor
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary H. Pendleton
15. Birthplace Va.

16 (a) Informant Mr. R.A. Brown
(b) Address 2526 N. Calvert Street

17 (a) Removal (b) Date thereof 1/1/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Beaverdam, Va.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) ____ (b) ____
(Date rec'd by registrar)

Filed JAN 2 1947 Huntington Williams, M.D.

vs.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1, 1947, at 10:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 30, 1946, to Jan. 1, 1947, and that I last saw him alive on Jan. 1, 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardiac Failure | 3 days. |
| Due to Chronic Myocarditis | Unknown. |
| Due to | |
| Other Conditions Generalized Arteria Sclerosis. (Include pregnancy within 3 months of death) | ? |

Date of operation None
Major findings of operation: None.
of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at ✓ M
(c) Where did injury occur? ✓
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? ✓
(Specify type of place)
(e) Means of injury ✓

23. Signature Frank N. Ogden. M. D.
Address 2701 N. Calvert St. Date signed Jan. 1, 47

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47067 G47067

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3036 St Paul
(c) Hospital or institution: (Home)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3036 St Paul
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Carrie May Miller

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Henry Walter Miller

6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) June 2, 1861

8. AGE: Years 85 | Months 11 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business home

FATHER
12. Name William Wicks
13. Birthplace Germany

MOTHER
14. Maiden Name Fetter
15. Birthplace Hampstead Md

16 (a) Informant Charles Walter Miller
(b) Address 2706 N. Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan-2-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Stewart Mortuary Co
(b) Address 1080 W Fayette

19 (a) JAN 2 1947 (b) Date received by Registrar

VS 180

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1947, at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 19__, to Dec 31 1946, and that I last saw h.e. alive on Dec 31 1946.

| | Duration |
|---|---|
| Immediate cause of death: Cerebral Vascular accident | 4 years |
| Due to: Arteriosclerosis | unknown |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury

23. Signature Francis W Gluck M. D.
Address 715 Park ave Date signed 12/31/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47068

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

93E ✓ Registered No. G47068

Please write or typewrite plainly in ink. Physicians: please write the causes of death clearly and legibly. Be sure to correctly supplied. The correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3004 Abell Av
(c) Hospital or institution: Home 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltotety
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3004 Abell Av
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Howard LeRoy Callis

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Ann M. Callis

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) June 12 1885

8. AGE: Years 61 | Months 6 | Days 19 | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Asst. Supt. Catholic Hammond

11. Industry or business Liquor Dealer

FATHER
12. Name Charles H. Callis
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary J. Codd
15. Birthplace Baltimore

16 (a) Informant Mrs Ann M. Callis (wife)
(b) Address 3004 Abell Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3 47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Stewart Mangle
(b) Address 1421 W North Ave

19 (a) JAN 2 1947 (Date filed by registrar) (b) [illegible] Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-31 1946, at 6 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1946 to Dec 31 1946. and that I last saw him alive on Dec 30 1946

Immediate cause of death: Acute congestive

Due to Heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy ✓

| | Duration |
|---|---|
| Acute congestive | |
| Heart disease | |
| | |
| | |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Francis J Kirby, M.D.
Address 110 E Northam Ave Date signed 1/3/47

VS 150

X

G17069 — G17069

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. ____

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address ____
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec.
(e) Length of stay in Baltimore (yrs., mos., or days) ____

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County ____
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1833 N Castle St
(If rural give location)
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

**3 (a) FULL NAME** RUDOLPH H. MAYFIELD

3 (b) If veteran, name war: SPANISH AMERICAN
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife ____
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 8/2/1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 4 | 26 | ____ hr. ____ min. |

9. Birthplace St. Louis, Missouri (Town, county, and state)
10. Usual Occupation House Painter
11. Industry or business Retired

FATHER
12. Name William Henry Mayfield
13. Birthplace Louisville, Ky.

MOTHER
14. Maiden Name Laura Gerstenberg
15. Birthplace Germany

16 (a) Informant Arthur P. Mayfield
(b) Address 121 Cunningham St. Vallejo, California

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-2-47 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 JAN 2 1947 (b) ____ d by ____ r

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 28 1946, at 8 P M

21. I certify that I took charge of the remains described above, held an Aug Ed Surg thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ____ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Hypertensive Cardio-Vascular Disease

Due to ____

Other Conditions ____

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur? ____
(c) Did injury occur at home, on farm, industrial place, in public place? ____ While at work? ____
(d) Means of injury ____

23. Signature William J. Helbrick M.D.
Medical Examiner.
Date signed Dec 29, '46

VS 151

G47070

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G47070 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3009 Clearview Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3009 Clearview Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James P. Hanson

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-1396

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | married |

6 (b) Name of husband or wife. Mary A. Hanson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 7 | 27 | hr. min. |

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Printer
11. Industry or business Self.

FATHER
12. Name James H. Hanson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sarah Price
15. Birthplace Baltimore, Md.

16 (a) Informant Mary A. Hanson
(b) Address 3009 Clearview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 / 4 / 47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Taylor Ave

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 4914 Belair Road

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

JAN 2 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 1946, at 8-15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 24 1946 to Dec 31 1946 and that I last saw him alive on Dec 30 1946.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Embolism | 1 day |
| Due to Chronic Myocarditis | 2 yrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E North Av Date signed Dec 31-46

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G47071 ✓ G47071

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

115B

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County A.A.Co.
(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. 6408 Arundelcove Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Adam N. Johnson ✓

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 216-05-3591

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wife - Helen A. JOHNSON

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 9-10-07

8. AGE: Years 39 | Months 3 | Days 20 | If less than one day: hr. min.

9. Birthplace Md. (Balto.) (Town, county, and State)

10. Usual Occupation Auto machinist

11. Industry or business

FATHER — 12. Name (Dec.) John Johnson
13. Birthplace Md.

MOTHER — 14. Maiden Name Barbara Wolfe
15. Birthplace Md.

16 (a) Informant Mrs. Helen A. Johnson
(b) Address 6408 Arundel Cove Ave., Brooklyn Md.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 1/2/47 (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL CEM.
Location ANNE ARUNDEL CO. MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTO. MD,

19 (a) (Date received by registrar) (b) Registrar

JAN 2 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 1946, 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-28-1946 to 12-30-1946, and that I last saw him alive on 12-30-1946

| Immediate cause of death | Duration |
|---|---|
| (a) Ruptured Aneurism | |
| Due to (b) Hypertension | |
| Due to (c) Heart | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chester Smith Jones M. D.
Address St Agnes Hosp Date signed 1/2/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MCD G47072
90290

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

937

Registered No. G47072

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 2 11
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2239 Fulton Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Alice Griffin or Alice V. Griffith

3 (b) If veteran, name war: NONE?

3 (c) Social Security Account No.: ?

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 8 | 19 | hr. min. |

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alexander Griffin
13. Birthplace England

MOTHER
14. Maiden Name Sarah Knight
15. Birthplace Canada

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/47 (month) (day) (year)
(c) Cemetery Loudon Park
Location Balto. Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa Ave. Balto. Md.

19 (a) (Date rec'd by registrar) (b) (Burial Permit)

VS 150 JAN 2 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 30 1946, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 19 1944 to Dec. 30 1946, and that I last saw her alive on Dec. 30 1946.

Immediate cause of death: Bronchopneumonia — Duration: 2 days

Due to:

Due to:

Other Conditions: Hypertension Heart Disease
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Rothman Jr. M. D.
Address Balto City Hosp. Date signed 1/31/47

Huntington Williams

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Certificate
G4703
G-67148

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 161a

Registered No. G4703

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Gorsden & Madison Aves.
(c) Hospital or institution Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore #15
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3904 Boarman Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy Maxwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | S |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/30/46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 0 | 0 | 2 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Emory Maxwell
13. Birthplace Malden, Mass.

MOTHER
14. Maiden Name June Emerick
15. Birthplace Maryland

16 (a) Informant mother
(b) Address

17 (a) BURIAL (b) Date thereof 1-2-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MT OLIVET
Location BALTO. MD.

18 (a) Funeral director GEO W. LITTLE
(b) Address 2200 EDMONDSON AVE

JAN 2 1947 (b)
(Date rec'd by registrar)

Huntington Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 1 1947, at 4.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/30 1946 to 1/1 1947 and that I last saw h[illegible] alive on 1/1 1947.

Immediate cause of death atelectasis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M W Kreps, M.D.

Address Md. Gen. Hosp. Date signed 1/1/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G47074

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

G47074 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5307 Saint Albans Way
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5307 Saint Albans Way (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillian Di Domenico
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Joseph F. Di Domenico (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28. 1899

8. AGE: Years 47 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Benjamin Apicella
13. Birthplace Italy

MOTHER
14. Maiden Name Antoinette Maffai
15. Birthplace Italy

16 (a) Informant Husband Joseph F. Di Domenico
(b) Address 5307 Saint Albans Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3. 47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Frank V. Pipitone
(b) Address 2818 E. Baltimore St.

19 (a) 1947 (Date rec'd by registrar) (b) [redacted] Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1946 at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945 to Dec 31 1946, and that I last saw him alive on 12/23 1946.

Immediate cause of death Coronary Thrombosis — Duration Sudden

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack A. Morgan
Address 107 E. Eager St. Date signed 1/1/47 M. D.

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. ... information should be carefully supplied. The

G47075

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

184

G47075 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 D
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. Winters Lane Ext. Catonsville
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Vivian McCoy Cameron

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | Widowed |

6 (b) Name of husband or wife James
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1925

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 21 | 5 MT. | 11 | hr. min. |

9. Birthplace Hamlet, N. C. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Nathaniel Cameron
13. Birthplace N. C.

MOTHER
14. Maiden Name Annie Duck
15. Birthplace N. C

16 (a) Informant Annie McLain
(b) Address Winters Lane Ext. Cat. 28 Md

17 (a) Removed (Burial, cremation, or removal) (b) Date thereof 1/2/46 (month) (day) (year)
(c) Cemetery or crematory
Location Sanford, N. C.

18 (a) Funeral director Joseph B. Locke Jr.
(b) Address 1864 N. Central Ave
(Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec. 28, 1946, at 5:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet Wound of brain

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-28-46 at 5:00 P.M. 17/3
(b) Where did injury occur? 603 N. Fremont
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Firearms - rifle

23. Signature Howard Wallace M.D. Medical Examiner.
Date signed 12-30-46

G47076

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

G47076 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2252 Brookfield ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2252 Brookfield ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Jonia Deitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Jennie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 72 | Months 11 | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Louis
13. Birthplace Russia

MOTHER
14. Maiden Name Rebecca
15. Birthplace Russia

16 (a) Informant Jennie Deitz
(b) Address 2252 Brookfield ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-2-47 (month) (day) (year)
(c) Cemetery or crematory Mt Hebron Israel
Location Baltimore ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1407 Balto St

19 (a) JAN 2 1947 (b)
(Date rec'd by registrar)

Huntington Williams Reg. M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-1- 1947 at 4P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1940 to Jan 1 1947
and that I last saw h[illegible] alive on Dec 24 1946
Immediate cause of death Coronary Thrombosis
Due to Sclerosis of arteries
Due to
Other Conditions emphysema
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

| Duration |
|---|
| |
| |
| |
| |

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Schapiro M. D.
Address 2028 Eutaw Pl, Date signed 1/2/47

VS 150

Correct age if especially important. Physicians: please write the causes of death clearly and legibly.

G47077 BALTIMORE CITY HEALTH DEPARTMENT G47077

# CERTIFICATE OF DEATH

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2116 Boyd St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

**3 (a) FULL NAME** Caroline Southerland (Southern)

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife: Benjamin Southern
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 (51) | 7 | 5 | hr. min. |

9. Birthplace: Howard County, Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: August Wittkowsky
13. Birthplace: Germany

MOTHER
14. Maiden Name: Anna Evertowsky
15. Birthplace: Germany

16 (a) Informant: Howard V. Southern
(b) Address: 2114 Boyd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-47 (month) (day) (year)
(c) Cemetery or crematory: Evangelical Lutheran
Location: Perryman, Md.

18 (a) Funeral director: George L. Schwab
(b) Address: 2101 Frederick Avenue

19 (a) (Date rec'd by registrar) JAN 2 1947 (b) Interment or Removal, M[illegible]

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 12/30 1946, at 7 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Dissecting aneurysm of aorta with massive hemorrhage into pericardial cavity.
Due to
Other Conditions: Hypertrophy of heart. Chronic cholelithiasis. Obesity.
(Conditions within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: George A. Merrill M.D.
Medical Examiner.
Date signed 12/31/46

G47078

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

186a

Registered No. G47078

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 83 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County —
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 N Charles St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Evelyn Smith (Evelyn Mathison Smith)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Mr. Tyler Smith

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 22, 1863.

8. AGE: Years 83 | Months 0 | Days 9 | If less than one day — hr. — min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Home maker

11. Industry or business Home maker.

FATHER
12. Name John Mathison
13. Birthplace Baltimore.

MOTHER
14. Maiden Name Elizabeth Mathison
15. Birthplace Baltimore.

16 (a) Informant (Sign) Mrs. Tyler Smith.
(b) Address 5303 Loch Raven Blvd 12.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3-47 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Stewart Memorial
(b) Address 1058 N Howard.

19 (a) — (Date rec'd by registrar) (b) — Registrar

JAN 2 1947 Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 1946, at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 28 1946 to Dec 31 1946 and that I last saw h[illegible] alive on Dec 31 1946

| | Duration |
|---|---|
| Immediate cause of death Bronchopneumonia. Terminal, Intestinal | 4 days |
| Due to Arteriosclerosis general. Arteriosclerotic Left Hemiparesis | 20 yrs |
| Due to (b) Hypertension, cardiovascular disease | 20 yrs |
| Fracture, simple, neck left femur | 10 yrs. 4 days |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 12/28 at ? M
(c) Where did injury occur? Home - 1120 N Charles
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Fell, floor, steps or stairs

23. Signature David Bernstein M. D.
Address Church Home & Hosp. Date signed Jan 1, 47

Howard J. Curtis, M.D.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47079 (1) G47079 (2) 131a

Registered No. G47079

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1318 McCulloh St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1318 McCulloh St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No.

3 (a) FULL NAME Landon Winston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1882

8. AGE: Years 64 | Months 1 | Days 26 | If less than one day hr. min.

9. Birthplace Tunstall Virginia
(Town, county, and state)

10. Usual Occupation Night Watchman

11. Industry or business

FATHER 12. Name James Winston
13. Birthplace Virginia

MOTHER 14. Maiden Name Arabella Saunders
15. Birthplace Virginia

16 (a) Informant Estelle H. Forcey
(b) Address 1319 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/47 (month) (day) (year)

(c) Cemetery or crematory Richmond Va.
Location Virginia

18 (a) Funeral director G. H. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

VS JAN 2 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31, 1946, at 11:31 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1, 1946 to Dec 31 1946 and that I last saw h[illegible] alive on Dec 30 1946

| Immediate cause of death | Duration |
|---|---|
| Cardio-Renal | 7 |
| Hypertension Dis | 7 |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. Thomas M. D.
Address 1207 N. Conkling Date signed 1/2/47

X 1/2/47

Correct any errors in spelling, punctuation, or abbreviations. Physicians: please write the causes of death clearly and legibly.

G47080

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

131a

G47080 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 506 N. Gilmore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 N. Gilmore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Otis Nichols

3 (b) If veteran, name war World #1

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1890

8. AGE: Years 56 | Months 10 | Days 10 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Grant Nichols
13. Birthplace Va

MOTHER
14. Maiden Name Annie Street
15. Birthplace Va.

16 (a) Informant Annie Nichols
(b) Address 506 N. Gilmore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/47 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1010 Brant Lane

19 (a) JAN 2 1947 (Date rec'd) (b) Huntingtown Williamsville, Md.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 29 19 46 at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21 19 46 to Dec 29 19 46 and that I last saw him alive on Dec 29 19 46.

Immediate cause of death Lobar Pneumonia — Duration 8 days

Due to Cardio Vascular Renal Disease — Duration Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Estelle Wm Frey M. D.
Address 928 Penna Ave Date signed Jan 2 47

G47081

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1637

Registered No. G47081

1. PLACE OF DEATH: UNIV. HOSP
(a) Baltimore City, Maryland
(b) Street address LOMBARD & GREENE STS
(c) Hospital or institution: UNIV. HOSP 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 51 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2606 Puget Al.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GERTRUDE LIVERPOOL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race B

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife CLINTON

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years 36 Months Days If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles Boone
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Maggie Boone
15. Birthplace Md

16 (a) Informant Clinton Liverpool
(b) Address 2606 Puget St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Elroy D Wilson
(b) Address 1000 Eastern Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

JAN 2 1947 Huntington Williams

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 29 DEC 1946 at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from NOV 8 1946 to DEC 29 1946
and that I last saw her alive on DEC 29 1946

| Immediate cause of death | Duration |
|---|---|
| SUFFOCATION | |
| Due to OBSTRUCTION FROM ACUTE TRACHEITIS FOLLOWING | |
| Due to THYROIDECTOMY. | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: ACUTE TRACHEITIS & OEDEMA.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
(f) Signature Robert C. Bauer M. D.
Address Univ. Hosp. Date signed 30 Dec 46

Write the causes of death clearly and legibly. Physicians please write especially important.

G47082

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G47082 Registered No.

Write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3310 Piedmont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-7
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3310 Piedmont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Sophie Seidman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Rubin Seidman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

| 8. AGE: | Years | Months | Days | If less than one day |
|---|---|---|---|---|
| | 63 | | | hr. min. |

9. Birthplace Poland (Town, county and state)

10. Usual Occupation housewife

11. Industry or business

FATHER — 12. Name Isaac — 13. Birthplace Poland

MOTHER — 14. Maiden Name Poland — 15. Birthplace Poland

16 (a) Informant Edw. Seidman
(b) Address 3310 Piedmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location

18 (a) Funeral director Isaac Lewis Inc
(b) Address 1409 E. Baltimore St

19 (a) (Date rec'd by registrar) Washington Williams, M.D. Registrar

VS 15 JAN 2 1947

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan 2 1947, at M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Nov 17 1946 to Jan 2 1947. and that I last saw h[illegible] alive on Jan 1 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure | 1 mos |
| Due to | |
| Due to Diabetes - arteriosclerosis - Nephritis | 3 yrs |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23. Signature** J Frederick Lentz M. D.

Address Keyser Bldg Date signed 1/2/47

X

G47083

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 94a

G47083 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1147 Ward St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 - 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1147 Ward St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Harry M. Sawyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~

6 (b) Name of husband or wife Margaret E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14th 1883

8. AGE: Years 63 | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Balto Transit Co.

FATHER
12. Name Greenlief Sawyer
13. Birthplace Maine

MOTHER
14. Maiden Name Mary Alice
15. Birthplace Charles Co Md

16 (a) Informant Mrs. Edward M. Sawyer
(b) Address 2335 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 | 3 | 47 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Longwood + Edmondson Ave

18 (a) Funeral director John J. Cowan & Son
(b) Address 903 Hollins St

19 JAN 2 1947 (Date rec'd by registrar) (b) Huntington Williams, MD

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 31 1946, at 6 P M

21. I certify that I took charge of the remains described above, held an Autopsy on Aug 4 Aug thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Stefford M.D. Medical Examiner.
Date signed Jan 1, 1947

VS 151

G47084

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1946

Registered No. G47084

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 844 W. Pratt St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 844 W Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward F Ruby

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25, 1915

8. AGE: Years 31 | Months 9 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Clerk
11. Industry or business Gordon Baker Co

FATHER
12. Name Geo W. Ruby
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Lenner B Hankey
15. Birthplace Baltimore Md

16 (a) Informant Mr. Geo W. Ruby
(b) Address 842 W Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3809 Frederick Ave

18 (a) Funeral director Sollers Howard & Gorsuch
(b) Address 901-03 Baltimore St

19 (a) Date rec'd by Registrar (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 30, 1946 at 7:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1946 to Dec 30 1946 and that I last saw him alive on Dec. 30 1946

Immediate cause of death Rheumatic Heart Disease — Duration unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Ramsen M. D.
Address 206 S. Gilmor St Date signed 12-31-46

VS 150

Huntington Williams, M.D.

X

G47085

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47085 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4305 GLEN ARM AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-1
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4305 GLEN ARM AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** WILLIAM K. BYRNE

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No. 220-07-4216

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife ADA M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 23, 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 5 | 8 | hr. min. |

9. Birthplace WHEELING W. VA.
(Town, county, and state)
10. Usual Occupation ESTIMATOR
11. Industry or business CONSOLIDATED ENG.

FATHER
12. Name JOHN A. BYRNE
13. Birthplace W. VA.

MOTHER
14. Maiden Name MARY O'MALLEY
15. Birthplace NEW YORK

16 (a) Informant MRS ADA M. BYRNE
(b) Address 4305 GLEN ARM AVE

17 (a) BURIAL (b) Date thereof JAN. 4, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MORELAND MEM. PARK
Location PARKVILLE, MD.

18 (a) Funeral director WILLIAM COOK, INC
(b) Address 1217 ST. PAUL ST

19 (a) (Signature of local registrar) (b) Huntington Williams
JAN 2 1947

VS 180

**MEDICAL CERTIFICATION**

20. DATE OF DEATH DEC. 31 1946, at 7 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/30 1944 to 12/31 1946, and that I last saw h[illegible] alive on 12/15 1946

| Immediate cause of death | Duration |
|---|---|
| CORONARY ARTERY THROMBOSIS | 30 MIN. |
| Due to (CORONARY ARTERIO SCLEROTIC HEART DISEASE) | 3 YRS. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
M.D.
Address 6331 Belvedere Date signed 1/1/47

X

G47086

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

157a G47086

Write the causes of death clearly and legibly. Physicians: please write correct age if especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1328 W. Balto St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Rose Lee ~~Poovey~~ Poovey

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1942

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 4 | | | hr. min. |

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

**FATHER**
12. Name Albert Lee Poovey
13. Birthplace Unknown

**MOTHER**
14. Maiden Name Mary Miles
15. Birthplace U.S.

16 (a) Informant Walter Nichols
(b) Address 1328 W. Balto. St.

17 (a) Removal (b) Date thereof 1/2/47 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Conover
Location North Carolina

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (Date received by registrar) JAN 2 1947 (Registrar) Hamilton Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-31 1946, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-31 1946 to 12-31 1946, and that I last saw h[illegible] alive on 12-31 1946.

| Immediate cause of death | Duration |
|---|---|
| Hydrocephalus | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Harbin, M. D.
Address Univ. Hosp. Date signed 1-2-47

VS 150

X

Lucie

G47087

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 117a

G47087 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age. Is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. [redacted] Virginia park ave
(If rural give location) Ocean Beach
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs. Lucie Pennebaker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/16/46, 75

8. AGE: Years 71 | Months 0 | Days 14 | If less than one day: hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Neale Johnson
13. Birthplace Montgomery

MOTHER
14. Maiden Name Hattie Langley
15. Birthplace Baltimore

16 (a) Informant patient
(b) Address Ocean Park ave - Ocean Forest

17 (a) Burial (b) Date thereof 1-3-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) Filed by registrar JAN 2 1947 (b) Registrar

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 12/30/46, 19, at 1:55 PM

**21.** I certify that death occurred on the date above stated; that I attended deceased from 12/16/46 19 to 12/30/46 19, and that I last saw h[illegible] alive on 12/30/46 19.

Immediate cause of death cardiac failure — Duration

Due to uncontrolled septic abortion and pleurisy

Due to hypostatic pneumonia and myocarditis, left (bronchial)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12/30/46

Major findings of operation: suppurated septic uterus and pleurisy

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph F. Antonelli M. D.
Address Church Home & Hosp. Date signed 12/31/46

G47038

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 42D

Registered No. G47038

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 440 GRINDALL ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 440 BRINDALL ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** WILLIAM A HOOPER

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-10-5959

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| MALE | WHITE | MARRIED |

6 (b) Name of husband or wife NELLIE HOOPER
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) AUG 13-1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 4 | 18 | hr. min. |

9. Birthplace BALTIMORE MD
(Town, county, and state)
10. Usual Occupation LABORER
11. Industry or business

FATHER
12. Name WILLIAM H HOOPER
13. Birthplace BALTIMORE MD

MOTHER
14. Maiden Name MARY CHAMAUGH
15. Birthplace BALTIMORE MD

16 (a) Informant NELLIE HOOPER
(b) Address 440 GRINDALL ST

17 (a) BURIAL (b) Date thereof JAN 2-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS CEM
Location BALTO CO
18 (a) Funeral director Bernard C Hartz
(b) Address 131 E West St
19 (a) (b)
(Date rec'd by registrar) Registrar

JAN 2 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH DEC 30 1946, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 25 1946 to Dec 30 1946, and that I last saw him alive on Dec 30 1946

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Edema | 2 days |
| Due to General Arteriosclerosis | 1 mo. |
| Due to Chronic Endocarditis | 3 mo. |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 1279 Fulton Ave N Date signed 12/31/46 M. D.

Hamilton Williams M.D.

G47089

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 8313

G47089 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15d
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3838 Park Heights ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** RACHEL ESTHER COHEN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Late Isaac
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1856

8. AGE: Years 91 90 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Joseph Katz
13. Birthplace Russia

MOTHER
14. Maiden Name U.K.
15. Birthplace Russia

16 (a) Informant Mrs. Ann Cohen
(b) Address 3838 Park Heights ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3/46 (month) (day) (year)
(c) Cemetery or crematory Herbert Herring Rites
Location Bowleys Lane

18 (a) Funeral director Sol Levinson + Bros
(b) Address 1124-26 W. North ave

19 (a) (Date rec'd by registrar) (b) Registrar

VR JAN 2 1947 Evelyn Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-2 1947 at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-30 1946 to 1-2 1947 and that I last saw h[illegible] alive on 1-2 1947

| Immediate cause of death | Duration |
|---|---|
| Bilateral hypostatic broncho pneumonia | |
| Due to Cerebral Krombosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry W Zyel M. D.
Address Levindale Home Date signed 1-2-47

X

G47090

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G47090 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3902 Hilton Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-11
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3902 Hilton Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Benjamin Orman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Evelyn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16, 1908

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 39 | 9 | 17 | hr. min. |

9. Birthplace New York City (Town, county, and state)
10. Usual Occupation
11. Industry or business Merchant

FATHER
12. Name Jacob Orman
13. Birthplace Russia

MOTHER
14. Maiden Name Gussie Henry
15. Birthplace Russia

16 (a) Informant Evelyn Orman
(b) Address 3902 Hilton Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 3, 1948 (month) (day) (year)
(c) Cemetery or crematory Shaarei Zion Cong. Cem.
Location Hamilton Ave Rosedale

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date received) (b) Huntington Hilligoss, M.D. Registrar

JAN 2 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-1- 1947, at 5:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1- 1947 to 1-1- 1947 and that I last saw him alive on 1-1- 1947

Immediate cause of death Myocardial infarction — Duration 1 hr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving M. Wagshal M. D.
Address 111 E. Lexington St Date signed 1-1-47

X

Dpct Certificate
G47091
G66226

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 161a

G47091
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street Blk 30
(c) Hospital or institution: South Baltimore Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 30
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 Clarkson St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Lee Cordelia Hayslup

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 31 Dec 46

8. AGE: Years | Months | Days | If less than one day 9 hr. 30 min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas Charles Hayslup
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Evelyn Cordelia Cain
15. Birthplace Baltimore

16 (a) Informant Father
(b) Address 1503 Clarkson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 2 47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Frederick Rd.

18 (a) Funeral director Kramer Funeral Home
(b) Address 1216 N. Charles St.

19 (a) [redacted] (Date rec'd) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 Dec 1946 at 3:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 31 Dec 1946 to 31 Dec 1946 and that I last saw h SL alive on 31 Dec 1946

Immediate cause of death: Respiratory failure
Pulmonary atelectasis?
Due to Fetal vascular shock.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address South Balto Gen'l Hosp Date signed 31 Dec 46

VS 150

Huntington Pathologist, M.D.

G47092

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1248

Registered No. G47092

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 913 South Binney Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Unkwn

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 913 South Binney Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charlotte Susan Larson

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife John Larson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-19-1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | 0 | 11 | hr. min. |

9. Birthplace Buffalo, New York (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Earnest Smith
13. Birthplace New York

MOTHER
14. Maiden Name Emma Rebecca Seabrease
15. Birthplace Baltimore, Maryland

16 (a) Informant Mary Lambdin (Aunt)
(b) Address 3117 O'Donnell Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-2-47 (month) (day) (year)
(c) Cemetery ~~Co-cemetery~~ Mount Carmel
Location 5712 O'Donnell Ext.

18 (a) Funeral director Tillard Zeiler Inc
(b) Address 403 S. Wolfe St., Balto., 31

19 (a) JAN 2 1947 Registrar
Huntington Williams

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 30 1946, at 10:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1946, to Dec 15 1946, and that I last saw h.e alive on Dec 15 1946.

| Immediate cause of death | Duration |
|---|---|
| Acute Cardiac Failure | |
| Due to Chronic Pneumonia Congestion | |
| Due to Cirrhosis of Liver | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward A. Flanigan Jr M. D.
Address 3503 Fait Ave. Date signed Dec 31, 46

G47093

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 92 C

G47093 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 6 E. Monument St
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1240 N. Carey St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Myrtle Rebhan

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | married |

6 (b) Name of husband or wife Lawrence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/26/96

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 3 | 5 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at Home

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Lawrence S. Rebhan
(b) Address 1240 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Lilly & Taylor
(b) Address 403 N. Wolfe St.

19 (a) JAN 2 1947 (Must be after registration) Huntington Williamsport, Md.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-1- 1947, at 2:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h. alive on 19. Died on arrival

| Immediate cause of death | Duration |
|---|---|
| Circulatory failure | |
| Due to Aortic Stenosis | |
| Due to Rheumatic Heart disease | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

**PHYSICIAN**
Underline the causes to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bertha Rader M. D.
Address Sinai Hospital Date signed 1-1-47

For D. R. Davis by Howard D. Mallonee, M.D. X

VS 150

507157 BCH G47094 B65583

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 157E

Registered No. G47094

Please write the causes of death clearly and legibly. Physicians: please write age if especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4624 O'Donnell St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME John H. Webb, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 5

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 12-3-46

| 8. AGE: Years | Months | Days (4 wks, 7) | If less than one day |
|---|---|---|---|
| | | | hr. ..... min. |

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name John Webb
13. Birthplace Maryland

MOTHER
14. Maiden Name Leona Wisniewski
15. Birthplace Maryland

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 1/2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Dale Lawn
Location Eastern Ave

18 (a) Funeral director Blaine & Hoffman
(b) Address 1639 Broadway

19 (a) 1947 (b).....
(Date received by registrar) Registrar

VS 150 Huntington for Baltimore, Md.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 1946 at 5:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1946 to Dec 30 1946 and that I last saw h... alive on Dec 30 1946

Immediate cause of death Congenital Heart Disease — Duration .....

Due to..... — Duration .....

Due to..... — Duration .....

Other Conditions..... — Duration .....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?
(Specify type of place)
(e) Means of injury.....

23. Signature Thomas C. McPherson M.D.
Address Johns Hopkins Hosp. Date signed 12-31-46

G47095

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47095 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 515 Parrish St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alverta Keys Hicks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Fe

5. Color or race: N

6 (a) Single, married, widowed, or divorced: (Separated)

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1912

8. AGE: Years 34 Months 6 Days If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER | FATHER

12. Name William Bagwell

13. Birthplace Va.

14. Maiden Name Annie Glenn

15. Birthplace Va.

16 (a) Informant Mildred Jackson

(b) Address 520 N. Parrish St

17 (a) Burial (Burial, cremation or removal) (b) Date thereof Jan. 3 1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion Cem.

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St.

19 (a) (b)
('d by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27 1946, at 2:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/26 1946 to 12/28 1946, and that I last saw h[illegible] alive on 12/28 1946.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 7

Due to

Due to

Other Conditions: Malnutrition + Debydration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address Provident Hosp. Date signed 12/30/46

2 1947 VS 150 Twittington Williams, M.D.

G47096

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47096 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1409 W. SARATOGA
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 W. SARATOGA (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** FRANK SISCO

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| m | C | married |

6 (b) Name of husband or wife Lula Sisco

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22 1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 10 | 7 | hr. min. |

9. Birthplace Rock Hall, Md. (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name James Sisco.
13. Birthplace Rock Hall, Md.

MOTHER
14. Maiden Name Eliza
15. Birthplace Rock Hall, Md.

16 (a) Informant Lula Smith Sisco
(b) Address 1409 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 2, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date signed by registrar) (b) Registrar

Jan 2 1947 Arlington Williams

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/29/46 19 at 7:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Weirs M.D.
Medical Examiner.
Date signed 12/29/46

X

G47097

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G47097

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 220 S. Collins Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 220 S. Collins Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** Edgar Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | white | widow |

6 (b) Name of husband or wife late Adelaide L. Burley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 6 | 23 | hr. min. |

9. Birthplace Washington D. C.
(Town, county and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Henry E. Stewart
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Lynch
15. Birthplace Md.

16 (a) Informant Mr. George E. Stewart
(b) Address 220 S. Collins Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry N. Wilhelm
(b) Address 4016 Edmondson Ave

19 JAN 2 1947 (Date rec'd by local reg.) (b) Huntington Williams, M.D.

VS 6

## MEDICAL CERTIFICATION

20. DATE OF DEATH 31 Dec. 1946, at 7:30 P.M.

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an inspection thereon and from the evidence (Autopsy or Inquiry)
obtained by said inspection find that said deceased came (Autopsy or Inquiry)
to his death on the day stated above.

Immediate cause of death Coronary Occlusion — Duration 1 Day

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury WM. H. KAMMER, JR.

23. Signature Wm. H. Kammer, Jr. M.D.
Medical Examiner.
Date signed 31 Dec. 1946

G47098

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47098 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address W. Fayette St. 28
(c) Hospital or institution:
Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4706 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Grace M. Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife Charles J. Mitchell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-2-77

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 3 | 29 | hr. min. |

9. Birthplace Baltimore, Md. Germany
(Town, county, and state)
10. Usual Occupation Teacher
11. Industry or business

FATHER
12. Name Albert Tauberstein
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Bergmann
15. Birthplace Germany

16 (a) Informant Mrs. A. Roy Green
(b) Address 4706 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 3, 1947 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave & Longwood St

18 (a) Funeral director Henry H. Tyler
(b) Address 4101 Edmondson Ave

19 JAN 2 1947 (b) Huntington Willard, M.D. Registrar
Rec'd by (Registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1946, at 7 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-14 1946, to 12-31 1946, and that I last saw her alive on 12-30 1946.

| Immediate cause of death | Duration |
|---|---|
| Cerebral hemorrhage | 17 days |
| Due to Hypertensive Cardio-vascular disease | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E. Farber M. D.
Address Bon Secours Hosp., Balto. Date signed 12-31-46

G17099

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1950

Registered No. G17099

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 322 South Fulton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 322 South Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** CHARLES L. REITH

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Annie E. Reith
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) March 4, 1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 9 | 26 | hr. min. |

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Butcher
11. Industry or business Kriel Company

FATHER
12. Name Nicholas Reith
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Annie E. Reith (wife)
(b) Address 322 South Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 Jan. 47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director H. B. Herbert & Son
(b) Address 1300 Eutaw Place. 17

19 (a) Date received by registrar JAN 2 1947 (b)

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 30 December 1946, at 3:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 26 1946, to Dec. 29 1946, and that I last saw h. alive on Dec. 29 1946.

Immediate cause of death Cardiac Failure — Duration

Due to Cardiac Dilatation + Hypertension — Duration

Due to Arteriosclerosis — Duration

Other Conditions Emphysema — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature K. Krulewitz M. D.
Address 2116 West Pratt St. Date signed Jan. 2, 1947

G47100

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1242

G47100 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4012 Fourth St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Baltimore (25)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4012 Fourth St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Albert Ruppert

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary B. Mitchell Ruppert
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) June 16, 1897

8. AGE: Years 49 | Months 6 | Days 14 | If less than one day: 15 hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Mgr. Restaurant
11. Industry or business Corn & Market

FATHER
12. Name Henry J. Ruppert
13. Birthplace Washington, D.C.

MOTHER
14. Maiden Name Helen Schaumann
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Mary B. Mitchell Ruppert (Wife)
(b) Address 4012-4th St., Balto 25, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 3, 1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Gwynn, Md.

18 (a) Funeral director J. Edward Evans
(b) Address 1402 Charles St Balto 30, Md

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 2 1947 Baltimore, Md.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1946, at 3:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-1 1946 to Dec 31 1946 and that I last saw h[illegible] alive on Dec 31 1946

Immediate cause of death: Coronary Thrombosis — Duration 1 hr

Due to: Carcinoma of Penis — 2 yrs

Due to: Arteriosclerosis — 2 yrs

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
21. Signature D. Thomas McGrath M. D.
Address 11 E. Read St Date signed 12-31-46

(2) Vernon 2684 X

G47101

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH √93

Registered No. G47101

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St. City
(c) Hospital or institution:
Little Sisters of the Poor 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** Gertrude Henselen

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | white | Widowed |

6 (b) Name of husband or wife Frank Henselen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 10 | 27 | hr. min. |

9. Birthplace West Minster Maryland (Town, county, and state)
10. Usual Occupation Practical Nurse
11. Industry or business

FATHER
12. Name Arnold Kleff
13. Birthplace Germany

MOTHER
14. Maiden Name Gertrude Vasbell
15. Birthplace Maryland

16 (a) Informant Little Sisters of the Poor
(b) Address

17 (a) Baltimore (Burial, cremation, or removal) (b) Date thereof Jan 4 1947 (month) (day) (year)
(c) Cemetery or crematory
Location Smyrna, Delaware

18 (a) Funeral director Rita Weidefeld
(b) Address 900 E. Biddle St.

19 JAN 2 1947 (Filed by Registrar) Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Jan 1 1947, at 3-48 M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1946, to Jan 1 1947, and that I last saw her alive on Dec 30 1946.

| Immediate cause of death | Duration |
|---|---|
| Edema Lungs | 1 day. |
| Due to — Chronic myocarditis | 5 yrs |
| Due to | |
| Other Conditions Arterio Sclerosis - Cerebral - | 3 yrs |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23. Signature** E Gill Hall M. D.
Address 1631 E. North av Date signed 1/2/47

VS 8

X

DR. CHARLES SLOAN
3200 EASTERN AVE
G47102

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 194a

Registered No. G47102

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 9 S. Chapel St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9 S. Chapel St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George F. Schmidt

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 31, 1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | - | 1 | hr. min. |

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation B. & O. R.R.

11. Industry or business

FATHER
12. Name George Schmidt
13. Birthplace Md.

MOTHER
14. Maiden Name Theresa Hopf
15. Birthplace Md.

16 (a) Informant Mrs. Theresa Pottgieser
(b) Address 9 S. Chapel St.

17 (a) Burial (b) Date thereof 1-4-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leopold J. Rueda
(b) Address 2316 Harford Road

19 (a) (Date rec'd by registrar) (b) Filed by Wm. M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 1 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/31 1946 to 1/1 1947 and that I last saw h. alive on 12/31 1946

Immediate cause of death Coronary Occlusion — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 3215 Eastern Ave Date signed 1/7/47

VS 150

G47103

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Lynch ✓6

G47103 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Sydenham Hospital, Balto. 12. 10-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 814 Webb Court.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** Donald Edwin Lynch.

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NO

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Single
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7 6 1929.

8. AGE: Years (18)17 | Months 11 10 | Days 1 29 | If less than one day ____hr. ____min.

9. Birthplace Baltimore, Baltimore Co. Md.
(Town, county, and state)
10. Usual Occupation Student.
11. Industry or business

FATHER
12. Name Daniel E Lynch.
13. Birthplace Balto

MOTHER
14. Maiden Name Margaret Baker
15. Birthplace Balto.

16 (a) Informant Margaret Baker Lynch
(b) Address 814 Webb Ct. Balto.

17 (a) Parkwood (b) Date thereof 1/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Leonard Ruth
(b) Address 5306 Harford Road

19 (a) JAN 2 1947 (b) Huntington Williams, M.D.
(Date received) (Registrar)

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/1/1947 at 1:09 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1/47 1947, to 1/1/1947, and that I last saw him alive on 1/1/1947.

Immediate cause of death: Meningitis Type undetermined — Duration
Due to: Meningococcus
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Hamer Yingling, M.D.
Address Sydenham Hospital Date signed 1/2/47

X

G47104 G47104

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 194a

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4801 Waethen Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4801 Waethen Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George F. Nieberlein

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Anna Emma Winters

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 11 | 29 | hr. min. |

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Retired Harness Maker

11. Industry or business

FATHER
12. Name John Nieberlein
13. Birthplace Md

MOTHER
14. Maiden Name Kate Stackmann
15. Birthplace Md

16 (a) Informant Mr Howard Nieberlein
(b) Address 306-A- Holly Drive

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-4-47 (month) (day) (year)
(c) Cemetery or crematory Oakland
Location Eastern Ave

18 (a) Funeral director Leonard J Ruck
(b) Address 53 Harford Rd

19 (a) 1947 (Date rec'd by registrar) (b) Registrar

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/1/47 19 at 7:30 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Weis M.D.
Medical Examiner.
Date signed 1/2/47

G47105

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 107

G47105 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Lionger Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto.
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 S. Decker Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Delmar Roark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 13 1940

8. AGE: Years | Months | Days: 18 | If less than one day: hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Delmar Roark
13. Birthplace Brkfld Missouri

MOTHER 14. Maiden Name Dorothy Kaczorowski
15. Birthplace Balto Md

16 (a) Informant Delmar Roark
(b) Address 1010 S. Decker Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location German Hill Road

18 (a) Funeral director Stephen J. Fruhauf
(b) Address 1000 N. Kenwood Ave

19 JAN 2 1947 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/31 1946 at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 27 1946, to Dec. 31 1946 and that I last saw him alive on Dec. 31 1946.

Immediate cause of death Resp. Collapse — Duration

Due to Pneumonia

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Pneumonia

over

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G.O. Hardesty M. D.
Address Sinai Hospital Date signed

VS 150

617106

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. 617106

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 934 S. Kenwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-4
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
Street No. 934 S. Kenwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Florian Kilian

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Mary Kilian
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3 1892

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 | 7 | 28 | hr. min. |

9. Birthplace Balto Md (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Balto Smelting Co

FATHER
12. Name Micheal Kulian
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Mrs. Mary Kilian
(b) Address 934 S. Kenwood Ave

17 (a) Burial (b) Date thereof 1/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Standish Cem
Location

18 (a) Funeral director Stephen J. Fiallenakis Inc
(b) Address 1000 S. Kenwood Ave

19 (a) JAN 2 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 1946 at 6:50 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 27 1946 to Dec 31 1946 and that I last saw h[illegible] alive on Dec. 30 1946

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | |
| Right Hemiplegia | |
| Due to Hypertension & Cardio | |
| Vascular Disease | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Andrew Hunkovsky M. D.
Address 2529 Eastern Ave Date signed

40 6645 062 G47107

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 75c

Registered No. G47107

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 Port 21
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adam C. Klingenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Mary Klingenberg (nee Flemer)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-2-81

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 5 | 29 | hr. min. |

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Police Department
11. Industry or business

FATHER
12. Name Adam Klingenberg
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Marsik
15. Birthplace Czech Republic

(a) Informant
Address JOHNS HOPKINS HOSPITAL

Burial (b) Date thereof 1/4/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or ~~Crematory~~ Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) (Date rec'd by registrar) (b) (Registrar)

JAN 2 1947 Baltimore, Md.

VS 150

## MEDICAL CERTIFICATION

55

20. DATE OF DEATH Jan. 1 1947 at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 27 1946 to Jan 1 1947 and that I last saw him alive on Jan 1 1946

| Immediate cause of death | Duration |
|---|---|
| PULMONARY EMBOLUS, THROMBUS | SUDDEN |
| SITE NOT DETERMINED | DEATH |
| Due to | |
| Due to | |
| Due to BRONCHOPNEUMONIA, BILL, LL | |
| Other Conditions GEN. PERITONITIS DUE TO | |
| RUPTURE OF SPLENIC ABSCESS | |

Operation (If female pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: ABOVE

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Freeman J. Stephens M. D.
Address Johns Hopkins Hospital Date signed 1-1-47

G47108 BCH G50599 BALTIMORE CITY HEALTH DEPARTMENT G47108

# CERTIFICATE OF DEATH 107

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2 800 N. Port Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Harvey James Shank

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/15/46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 6 mos. | 6 | 16 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Harvey Shank
13. Birthplace Curtis Bay, Md.

MOTHER
14. Maiden Name Hilda Marousek
15. Birthplace Baltimore, Md.

16 (a) Informant Parents
(b) Address 800 N. Port Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rod. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) (Date rec'd by registrar) (b) Hunter & Son Baltimore, Md.

JAN 2 1947

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 12/31/46 1946, at 4 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/31/1946, to 12/31/1946, and that I last saw him alive on 12/31/46

Immediate cause of death: Aspiration Pneumonia — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death).

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Sinai Hosp. Date signed 1/1/47

X

G47109

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G47109

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1205 Glyndon Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Glyndon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** George Louis Rozgatis

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. 215-01-4901

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | W | Married |

6 (b) Name of husband or wife Pauline
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | | | hr. min. |

9. Birthplace Lith. (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

MOTHER - FATHER
12. Name ? Rozgatis
13. Birthplace Lith
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Pauline Rozgatis
(b) Address 1205 Glyndon ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Beloit Rd

18 (a) Funeral director Joseph Lasinski Jr
(b) Address 601 Washington Blvd

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

JAN 2 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1947, at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1946 to Jan 1 1947 and that I last saw h.i.m. alive on Dec 31 1946.

| Immediate cause of death | Duration |
|---|---|
| Coronary Occlusion | 1 hr. |
| Due to Arteriosclerotic Cardio-Vascular Disease | 8 yr. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

John P. Urlock, Jr. M. D.
Signature
Address 1227 Wash. Blvd Date signed Jan 1 1947

G47110

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G47150

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland D.of.
(b) Street address 5139 Wetheredsville Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5139 Wetheredsville Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Norval E. Crosby

3 (b) If veteran, name war --

3 (c) Social Security Account No. 213-10-0762

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Margaret W. Crosby
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1892

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 | 11 | 7 | hr. min. |

9. Birthplace Prince George Co., Md.
(Town, county, and state)
10. Usual Occupation Motorman
11. Industry or business Balto. Transit Co.

FATHER
12. Name Marion Crosby
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Moreland
15. Birthplace Md.

16 (a) Informant Mrs. Margaret W. Crosby
(b) Address 5139 Wetheredsville, Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-47 (month) (day) (year)
(c) Cemetery or crematory Xx Good Shepherd
Location Rockland, Howard Co., Md.

18 (a) Funeral director L. Howard Strong
(b) Address 3207 W. North Ave.,

JAN 2 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/1 1947, at 7:20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Sulewski M.D.
Medical Examiner.
Date signed 1/1/47

G47111

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 43a

Registered No. G47111

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2643 Maryland Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2643 Maryland (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ella (Nellie) Cusack

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widowed |

6 (b) Name of husband or wife Thomas E. Cusack
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2/12/1863

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 10 | 18,9 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Martin Buckley
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth Buckley
15. Birthplace Ireland

16 (a) Informant Elizabeth Cusack MacDonald
(b) Address 2643 Maryland Ave.

17 (a) Burial (b) Date thereof Jan. 4, 47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location
18 (a) Funeral director Chas. F. Cowan & Son
(b) Address 118 W. Mt. Royal Ave
19 (d) JAN 2 19 47 Registrar Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 1 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/25 1946 to Jan 1 1947 and that I last saw h[illegible] alive on Dec 31 1946

Immediate cause of death: Cerebral Hemmitage
Duration: Jan 28 1946

Due to Pneumonia & left Arm Pleg

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. L. [illegible] M.D.
Address 2818 E. Pratt St. Date signed 1/2/47

VS 150

47112

MGD 96444

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G47112

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4240 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 2 28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2204 Cambridge St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Helen Theresa Brock

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1917

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 29 | - | - | hr. min. |

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Lewatowski
13. Birthplace Pa.

MOTHER
14. Maiden Name Cecelia Frances Jaskulski
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 1-4-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore Md.

18 (a) Funeral director George A Weber
(b) Address 705 S. Ann st

19 JAN 2 1947 (b) Hamilton Williams, M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 31 1946, at 5:30AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1945, to Dec. 31 1946, and that I last saw her alive on Dec. 31 1946.

| Immediate cause of death | Duration |
|---|---|
| | |
| Due to Pul. T.B. | 15 Years |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. J. Hartz M. D.
Address Balto City Hosp Date signed 1-2-47

VS 150

G47113

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G47113

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 804 W 37th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 804 W 37th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leroy J. Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-03-5209

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Hazel E. Smith
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Aug 20, 1903

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 43 | 4 | 12 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Retired Guard.
11. Industry or business Bath Steel Co.

FATHER
12. Name Wm. Smith
13. Birthplace Maryland.

MOTHER
14. Maiden Name Amelia Hess.
15. Birthplace Maryland.

16 (a) Informant Hazel E. Smith
(b) Address 804 W 37th St.

17 (a) Burial (b) Date thereof Jan 4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Frederick Road.

18 (a) Funeral director Clarence J. Donovan
(b) Address 3615-17 Eastern Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

JAN 2 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 1, 1947, at 6 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 5 1946 to Jan. 1 1946 and that I last saw him alive on Dec. 15 1946

Immediate cause of death Coronary Thrombosis — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton Segenuk M. D.
Address 1419 W Fayette St Date signed 1/2/47

X

G17114 BCH G47114

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G 41409 / 107

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1404 Myrtle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Linda Ann Dugger

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1946.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 11 | 1 | hr. min. |

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Milton Dugger
13. Birthplace Md.

MOTHER
14. Maiden Name Constance
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto City

18 (a) Funeral director Charles L. Law
(b) Address 162 Mad. Ave.

19 (a) JAN 2 1947 (Date rec'd by registrar) (b) Katie Williams, Reg.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 1, 1947, 8.30pm M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 29 1946 to Jan. 1 1947, and that I last saw h. or alive on Jan. 1 1947.

| Immediate cause of death | Duration |
|---|---|
| Acute cardiac failure | 1 da |
| Pulmonary edema | 1 da |
| Due to Bronchopneumonia | 2 da |
| Intestinal anemia + obstruction | 3 mos. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Wilton E. Snyder M. D.
Address Balto City Hosp Date signed Jan 2 '47

X

G47115 ✓ G47115

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

Registered No.

G47115

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2116 Jefferson (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anna M Heim

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Henry J Heim
6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Nov 2 1891

8. AGE: Years 55 | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Joseph Hick
13. Birthplace Balto

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Edw J Heahn
(b) Address 2116 Jefferson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Welsh Funeral Home
(b) Address 2008 Orleans St

JAN 2 1947 (Date rec'd by registrar) (By) Washington Williams Reg'r

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 31 1946, at 2 53P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 31 1946 to Dec 31 1946, and that I last saw her alive on Dec 31 1946.

Immediate cause of death Respiratory failure — Duration

Due to Subarachnoid hemorrhage

Due to Hypertensive & arteriosclerotic cardio-vascular disease

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Heinz Blessinger M.D.
Address Sinai Hospital Date signed 12/31/46

937

VS 150

G47116

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

93E

Registered No. G47116

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4634 York Road
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 71 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County ----------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4634 York Road
(If rural give location)
(e) Citizen of foreign country? ---------- (Yes or No)
If yes, name country ----------

3 (a) FULL NAME William A. Whittle

3 (b) If veteran, name war ----------
3 (c) Social Security Account No. ----------

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Alice Krager
6 (c) If alive, give age ---- years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1875

8. AGE: Years 71 | Months 0 | Days 19 | If less than one day ---- hr. ---- min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Chemist
11. Industry or business ----------

FATHER
12. Name Edward Dorsey Whittle
13. Birthplace Maryland

MOTHER
14. Maiden Name Alice E. McDonald
15. Birthplace Maryland

16 (a) Informant Philip H. Whittle
(b) Address 4634 York Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. H. Meare & Son
(b) Address 805 N. Calvert St.

19 (a) 1947 (Date received by registrar) (b) Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Dec. 31, 1946, at 6.15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 30, 1946, to Dec. ---, 19--, and that I last saw him alive on Dec. 30, 1946.

| Immediate cause of death | Duration |
|---|---|
| Pneumonia, massive bronono. | 3 days |
| Due to Chronic bronchitis, | |
| Due to Heart disease, Mycardial, | 2 yrs ? |
| Due to Cornary disease. | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Autopsy?

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Dorsey Whittle M.D. M. D.
Address 1229 N. Calvert St. Date signed

VS 150

G47117 G47117

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 95c

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 742 N Patterson Park Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Done
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 742 N Patterson Park Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles Kvicala Jr.

3 (b) If veteran, name war None
3 (c) Social Security Account No. 218-09-7393

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Marie A. Kvicala
6 (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) Dec 1 1913

8. AGE: Years 33 | Months 1 | Days 0 | If less than one day XX hr. min.

9. Birthplace Baltimore (Town, county and state)
10. Usual Occupation Radio Engineer
11. Industry or business W.C.A.O

FATHER
12. Name Charles Kvicala
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Vera Hanzlik
15. Birthplace Czechoslovakia

16 (a) Informant Marie A Kvicala
(b) Address 742 N Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave & Edgemere

18 (a) Funeral director George Kuth Inc
(b) Address 1735 Hartford Ave

19 2 1947 (b) Baltimore, Md Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 1, 1947, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1947 to Jan. 1 1947
and that I last saw h[illegible] alive on Jan 1 1947

Immediate cause of death Malignant Hypertension
Cardio Hypertrophy
Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Andrew Kuntzwork M. D.
Address 2594 Eastern Ave. Date signed

VS 150

G47118

BALTIMORE CITY HEALTH DEPARTMENT ✓ G47118 Registered No.

# CERTIFICATE OF DEATH §3a

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: 1708 Eutaw Place
(c) Hospital or institution: Elmhurst Nursing Home 9/16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days): Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: Md. (b) County: City
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 1514 E. Lanvale Street
(If No, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME:** Emma Virginia Mitchell

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: George W. Mitchell
6 (c) If alive, give age: D years
7. Birth date of deceased (mo., day, yr.): Feb. 7th., 1872
8. AGE: Years: 74 Months: 10 Days: 24 If less than one day: #### min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: At Home
11. Industry or business

FATHER
12. Name: Robert Murphy
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: Mr. Robert A. Smith
(b) Address: 1514 E. Lanvale Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan. 4, 1947 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Frederick Rd. Balto: Md.
18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue
19 (a) Date rec'd by registrar 1947 (b) [illegible] Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Dec. 31st. 1946 at 7.45 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 12-15-46 to 12-31 1946 and that I last saw her alive on 12-30 1946.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | |
| Due to: Adv. Arteriosclerosis | |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: Louis Grant M. D.
Address: 1700 Eutaw Pl. Date signed: 1-1-47

2 VS 150 1947 X

G47119

BALTIMORE CITY HEALTH DEPARTMENT ✓ G47119
CERTIFICATE OF DEATH 194a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1527 N.Bond Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 N.Bond Street
(If no No, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Maria Fleischmann

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1st, 1857

8. AGE: Years 89 | Months 11 | Days 29 | If less than one day hr. min. ######

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired seamstress
11. Industry or business Hospital

FATHER
12. Name John Fleischmann
13. Birthplace Germany

MOTHER
14. Maiden Name Anna (Unknown)
15. Birthplace Germany

16 (a) Informant Joseph T. Reese
(b) Address 1527 N.Bond Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 3, 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) (Date received by registrar) 1947 Hampton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30 1946 at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 5, 1946 to Dec. 30, 1946 and that I last saw her alive on Dec. 29, 1946.

| Immediate cause of death | Duration |
|---|---|
| Cerebral hemorrhage | 2 days |
| Due to Arteriosclerosis | 2 yrs. |
| Due to | |
| Other Conditions Coronary occlusion 2 yrs. | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Otho S. Fitzgerald M. D.
Address 1613 E. North Ave. Date signed 12-31-46.

VS 150

647120

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

647120 Registered No. 61

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1502 Division (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** James Mosley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace unknown (Town, county, and state)

10. Usual Occupation unknown

11. Industry or business unknown

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant John H. Mosley
(b) Address 1904 - 3rd St NW

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 1-6-47 (month) (day) (year)
(c) Cemetery or crematory
Location Wash DC

18 (a) Funeral director Thomas Wagner
(b) Address 389-R 2 ave NW Wash DC

19 (a) (Date received by registrar) 1947 (b) Huntington Williams M.D.

JAN 3

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2 1947, at 3:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2 1947, to 1/2 1947, and that I last saw h(im) alive on 1/2/1947

| Immediate cause of death | Duration |
|---|---|
| Diabetic Coma | |
| Due to Diabetes Mellitus | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address 844 N. Carey St. Date signed 1-3-47

X

G47121

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

52a

G47121
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Edward o Greene H
(c) Hospital or institution:
University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Anne Arundel Co.
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Lilo Slack~~ Lila (Lilla) Trenholm Slack

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April (1st) 1943

8. AGE: Years 3 | Months 8 | Days 9 (2nd) | If less than one day hr. min.

9. Birthplace Annapolis, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Leslie M. Slack
13. Birthplace Michigan

MOTHER
14. Maiden Name Catherine Hopkins
15. Birthplace Annapolis, Md.

16 (a) Informant Mrs. Helen Hoster
(b) Address Annapolis, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 5, 1947 (month) (day) (year)
(c) Cemetery or crematory Christ Church Cemetery
Location Owingsville, Md

18 (a) Funeral director L. Willis Lamoreaux
(b) Address 1003 W. Baltimore St.

19 (a) (b)
(Date received by registrar) Huntington Williams, M.D.
JAN 3 1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 2 1947, at 6.20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17 1946, to 1-2 1947, and that I last saw her alive on 1-2 1946.

| Immediate cause of death | Duration |
|---|---|
| (a) Lung fail | |
| Due to (b) Generalized Carcinomatosis | |
| Due to (c) Wilm's Tumor | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard J. Corn M. D.
Address University Hosp Date signed

1-2-46

7122

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

Registered No. 37122

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1917 Orleans St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 Orleans St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Walter L.Burns

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Anna M.Burns
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan.24-1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 11 | 6 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired Barber
11. Industry or business

FATHER
12. Name John A.Burns
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Julia M.Williams
15. Birthplace Balto. Md.

16 (a) Informant Anna L.Burns
(b) Address 1917 Orleans St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan.3-47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cem.
Location Windsor Mill Road

18 (a) Funeral director John A.Miller
(b) Address 2334 Jefferson St.

JAN 3 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1946, at 11 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1946 Dec 30 1946
and that I last saw deceased alive on Dec 30 1946

Immediate cause of death: General Arteriosclerosis Chronic Myocarditis — Duration 5 yrs 5 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Watson L. Solomon
Address 129 S. Bway Date signed 1/2/47

X

17123

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

V G47123

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1622 N. Wolfe St
(c) Hospital or institution: g1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1622 N. Wolfe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Arnold G. Holste

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~ |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of ~~husband~~ wife Florence B. Holste
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14th 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 11 | 18 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Asst Engineer
11. Industry or business Consolidated Beef Co

FATHER
12. Name Arnold G. Holste
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Zimmerman
15. Birthplace Balto. Md.

16 (a) Informant Mary C. Clark (Sister)
(b) Address 1622 N. Wolfe St.

17 (a) Burial (b) Date thereof 1-6-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

JAN 3 1947
(Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 2nd 1947, at 7a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1946 to Jan 2 1947, and that I last saw h~~im~~ alive on Jan 2 1947.

Immediate cause of death: Coronary Heart disease

| Duration |
|---|
| |
| |
| |
| |
| 1 yr. |

Due to Arteriosclerosis

Due to

Other Conditions Hemiplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Steele M. D.
Address 7714 - W. North Ave Date signed Jan. 4/47

X

VS 150

7124

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. G47124

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3037 Elliott st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3037 Elliott St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Clara E. Stonesifer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, ~~widowed, or~~ divorced: |
|---|---|---|
| Female | White | Separated |

6 (b) Name of husband Edward Stonesifer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 29th 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 11 | 2 | hr. min. |

9. Birthplace Hanover Pa
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Robert Gracey
13. Birthplace Pa.

MOTHER
14. Maiden Name Catherine (Unknown)
15. Birthplace Pa.

16 (a) Informant Mrs Mahlon Stokes
(b) Address 605 N. 4th St.

17 (a) Burial (b) Date thereof 1/4/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Oak Lawn
Location Eastern Ave., Extended

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

Date rec'd JAN 3 1947 (b) Huntington Williams, M.D.

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Jan 1st 1947, at 2:08 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6 July 1946, to 1 JAN. 1947, and that I last saw h~~e~~ alive on 1 JAN. 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 2 days |
| Due to Generalized arterio sclerosis | 6 yrs. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Clayton W. LeDoux M.D.
Address 601 S. Ellwood Ave. Date signed 1/2/46

VS 150

G47125

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

111a

Registered No. G47125

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3038 Mt Elderry St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3038 Mt Elderry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Marie M. Thoms

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| — | — |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | W. | Married |

6 (b) Name of husband or wife Geo. H. Thoms
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17-1898

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 48 | 10 | 13/14 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Geo Whicker
13. Birthplace Baltimore

MOTHER
14. Maiden Name Sarah Battee
15. Birthplace Baltimore

16 (a) Informant Mr. Geo. H. Thoms
(b) Address 3038 Mt Elderry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 4 47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore

18 (a) Funeral director Philip Herzig Sons
(b) Address 2024 Aliceanna St

19 (a) [illegible] rec'd by [illegible] (b) [illegible]

JAN 3 1947

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan 1 1947 at 4 A. M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from 12-3 1946 to 12-31 1946 and that I last saw h[illegible] alive on 12-31 1946

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Embolism | [illegible] |
| Due to Arteriosclerosis | 3 ? yrs |
| Due to Malignant Hypertension | 4 yrs |
| Other Conditions — | |

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

**23.** Signature [illegible] M. D.
Address 1901 E. Mon. St Date signed 1-2-47

Spec.—8-24-14—M. & T.—2000 Blks.

7126

# HEALTH DEPARTMENT—CITY OF BALTIMORE G47126

CERTIFICATE OF DEATH. 92B

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 401 Woodford Ave ST.; WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Weir Jarnet

(Residence in Baltimore: No. 401 Woodford Ave. St.; yrs., mos., da.)

## PERSONAL AND STATISTICAL PARTICULARS.

| 3-SEX. | 4-COLOR OR RACE. | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) |
|---|---|---|
| Female | White | Married |

6-DATE OF BIRTH, Aug (Month) 3rd (Day), 1889 (Year)

7-AGE, 57 yrs. 4 mos. 29 da. | If LESS than 1 day, ....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Own Home

9-BIRTHPLACE, (State or Country), Easton Md.

PARENTS.

10-NAME OF FATHER, Douglas Weir

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Mary M. Satterfield

13-BIRTHPLACE OF MOTHER (State or Country), Easton Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward D. Jarnet

(Address) 401 Woodford Rd

15- JAN 3 1947 19[illegible] Huntington Williams, M.D.

## MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 2 (Day), 1947 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1946, to Jan 2 1947, that I saw h[illegible] alive on Jan 1 1947, and that death occurred, on the date stated above, at 9.40 A.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) 5 yrs. mos. da.

CONTRIBUTORY (Secondary) Dropsy

(Duration) yrs. 15 mos. da.

(Signed) R. D. Sellman M. D.

Jan 2, 1947 (Address) Towson Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, [illegible] Cem. Balto. Md. | DATE OF BURIAL, [illegible] 1947

20-UNDERTAKER, Hilliard Cook Inc. | ADDRESS 1217 St. Paul St.

G47127 ✓ G47127

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2756 Pelham ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town 2756 Pelham ave, (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John M Schaefer

**3 (b) If veteran, name war**

**3 (c) Social Security Account No** 218-14-8623

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Widowed |

**6 (b) Name of husband or wife** Barbara T

**6 (c) If alive, give age** years

**7. Birth date of deceased (mo., day, yr.)** April 18-74

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 8 | 13 | hr. min. |

**9. Birthplace** Balto (Town, county, and state)

**10. Usual Occupation** Retired Policeman

**11. Industry or business**

**FATHER**
12. Name Frederick Schaefer
13. Birthplace Germany

**MOTHER**
14. Maiden Name
15. Birthplace Germany

16 (a) Informant George Schaefer
(b) Address 2756 Pelham

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 4-47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Balto

18 (a) Funeral director Jer J Stein & Son
(b) Address 3001 Kentucky ave

JAN 3 1947 (Date rec'd by Registrar) (b) [illegible] Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Dec 31 1946, at 10:30 AM

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec 1946, to Dec 31 1946 and that I last saw h alive on Dec 31 1946.

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | |
| Due to Arteriosclerotic | |
| Due to Cardio-Vascular Disease | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23. Signature** C H Stevens M.D.

Address 3400 Erdman Ave Date signed 1/1/47

VS 150

17128 B.C. 965587 ✓ G47128

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 160a

Registered No. A52149

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2942 Clifton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patricia Ellen (Baby Girl) RIGGIN "B"

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-21-46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 8 | hr. min. |

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William E. Riggin
13. Birthplace Md

MOTHER 14. Maiden Name Carolyn ?
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITEL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo JAN 2 1948

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 3 1947 (Date rec'd by registrar) Thomas Jon Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 29 1946 at 12 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-21- 1946, to 12-29 1946 and that I last saw her alive on 12-29- 1946

Immediate cause of death Respiratory failure — Duration

Due to Prematurity.

Due to ?

Other Conditions ? Fibromyoma
hemorrhage
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Barton Childs M.D.
Address Johns Hopkins Hosp Date signed 12-29-46 M. D.

VS 150

159

47129 Birth Certificate G-65846

BALTIMORE CITY HEALTH DEPARTMENT ✓ G47129

# CERTIFICATE OF DEATH 160a

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2847 Huntingdon (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-46

8. AGE: Years | Months | Days: 1 | If less than one day: 30 hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Clifton Williams
13. Birthplace Md

MOTHER 14. Maiden Name Shirley Krantz
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Locat Johns Hopkins Medical Schoo JAN 2 1947

18 (a) Funeral director Commissioner of Health
(b) Address

JAN 3 1947 (Date rec'd by registrar) Huntington for Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 1946, 3 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 25 1946 to Dec 26 1946 and that I last saw him alive on Dec 26 1946.

Immediate cause of death: Cerebral hemorrhage Resp water failure.

Due to Congenitally unexpanded lung.

Due to

Other Conditions 1. Intravenous hemorrhage.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Burton Childs M. D.
Address Johns Hopkins Hosp Date signed (Dec 27) -46

VS 150

157 M

G47130

5-06793 BC# G65634

BALTIMORE CITY HEALTH DEPARTMENT X

# CERTIFICATE OF DEATH √159

Registered No. G47130

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Dundalk, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 525 New Pittsburgh Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6. (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 22-46

8. AGE: Years 5 | Months | Days 5 | If less than one day hr. min.

9. Birthplace J. H. H. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Jacqueline Boyer Walker

15. Birthplace

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Location Johns Hopkins Medical Schoo JAN 2 1947

18 (a) Funeral director Commissioner of Health

(b) Address

JAN 3 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1946 at 11:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 22 1946 to Dec 27 1946 and that I last saw him alive on Dec 27 1946.

Immediate cause of death Respiratory failure — Duration 5 days

Due to Prematurity

Due to

Other Conditions Atelectasis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Barton Child M.D.

Address [illegible] Date signed 12-30-46

VS 150

47131 364870 BCH G65632 BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

G47131 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Ind. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 502 N. Arlington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy Chamberlain

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Black | — |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-20-46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 2 | hr. min. |

9. Birthplace J. H. Hosp. Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Louise Chamberlain
15. Birthplace ?

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo JAN 2 1946

18 (a) Funeral director Commissioner of Health
(b) Address

JAN 3 1947 (Date rec'd by registrar) Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 22 1946, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 20 1946 to Dec 22 1946 and that I last saw him alive on Dec. 22 1946.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure. | |
| Due to Prematurity | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Barton Childs M. D.
Address Johns Hopkins Hosp. Date signed 12-22-46

VS 150

G47132

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G47132 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3311 Mount St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 78 11 11

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3311 E. Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PAUL MUELLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race WHT | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 20 1868

8. AGE: Years 79 | Months 10 | Days 11 | If less than one day ....hr. ....min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Paul Mueller
13. Birthplace Germany

MOTHER 14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Mrs Fannie Schreiner
(b) Address 312 S Pontiac St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1/4/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk Cemetery
Location Frederick Ave

18 (a) Funeral director Geo. H. Leimbach
(b) Address 1 W N Lyndhurst St

19 (a) (Date received) JAN 3 (b) 1947 Harry [illegible] Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 1st. 1947, at 8 a.m. p.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 30 1946 to Jan 1. 1947, and that I last saw him alive on Jan 1st 1947.

| | Duration |
|---|---|
| Immediate cause of death Coronary Thrombosis | 1 Day |
| Due to arteriosclerotic coronary disease | 1 Yr. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene H Krupp

Address 3030 Edmondson Ave Date signed M. D. 1/2/47

VS 150

G47133

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47133 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 946 N. Chester St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore - 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 946 N. Chester St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Amelia Duchanek

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband ~~or wife~~: Edward A. Duchanek

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) April 20, 1882

8. AGE: Years 64 | Months 8 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation House-wife

11. Industry or business —

FATHER
12. Name John Doyle
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ida Meyers
15. Birthplace Balto. Md

16 (a) Informant Edward A. Duchanek
(b) Address 946 N. Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/47 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location O'Donnell St

18 (a) Funeral director Leo H. Leyhan
(b) Address 1214 N. Lyndhurst St

19 (a) ____ (Date rec'd by Registrar) (b) ____ Registrar

JAN 3 1947

VS 3

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 1 1947, at 11:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1945 to Jan. 1 1947 and that I last saw h.[illegible] alive on Dec 30 1946.

Immediate cause of death: Acute Dilatation of Heart
Due to: Myocardial Degeneration
Due to: Hypertension of Heart
Other Conditions: Hypertension
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations: —
of autopsy: —

| Duration |
|---|
| 5 min |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Vincent D. Dostka M. D.
Address 845 N. Patterson Park Ave Date signed 1/2/47

X

JL - 10716 C47134 BALTIMORE CITY HEALTH DEPARTMENT Registered No. C47134

# CERTIFICATE OF DEATH 83a

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 831 Eutaw St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Albert E. KEENER

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Widowed |

6 (b) Name of husband or wife Mary Burns Keener
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1862

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 84 ? | 9 ? | 1 ? | hr. min. |

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation O. A. A.
11. Industry or business

FATHER
12. Name John Keener
13. Birthplace Md. (Balto.)

MOTHER
14. Maiden Name Susan Holmes
15. Birthplace Md. (Balto.)

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 1/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTIMORE, MD.

19 (a) (Date rec'd) (b) Registrar

JAN 3 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2 1947, at 6.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 27 1946, to Jan. 2 1947, and that I last saw h[illegible] alive on Jan. 2 1947.

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia | 2 days |
| Due to | |
| Due to | |
| Other Conditions Cerebrovascular accident | 1 wk |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.
Address Balt. City Hosp. Date signed 1/2/47

107

G47135

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G47135

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1353 S. Ponca St.
(c) Hospital or institution: V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1353 S. Ponca St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Bessie F. Rose

3 (b) If veteran, name war —
3 (c) Social Security Account No. None

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 / 93

8. AGE: Years 53 54 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace Eastern Shore Md. (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name George Taylor
13. Birthplace Va.

MOTHER 14. Maiden Name Green
15. Birthplace Baltimore

16 (a) Informant William Rose
(b) Address 1353 S. Ponca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 4/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore

18 (a) Funeral director Fred W. Ozagunaki
(b) Address 1947 Eastern Ave.

19 (a) JAN 3 1947 (registered by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 5 1945 to Dec 31 1946 and that I last saw h alive on Dec 31 1946.

Immediate cause of death: General arteriosclerosis / Chronic myocardiotis — Duration 2 yrs / 3 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nelson L. Holeman M.D.
Address 129 S. Bway Date signed 1/2/47

VS 150

G47136

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 186a

Registered No. G47136

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 24-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1/2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 234- E. Cross St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Catherine J. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Jean a. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | | | hr. min. |

9. Birthplace Liverpool, (Town, county, and state)

10. Usual Occupation St. Nurse

11. Industry or business

12. Name James Jennings

13. Birthplace Liverpool, -

14. Maiden Name Rumford - ?

15. Birthplace England

16 (a) Informant Mr John Jennings

(b) Address 1052 Rhenandale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-47 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Old Frederick Road

18 (a) Funeral director J. J. Foley & Sons

(b) Address 31 & 3 Light St.

19 (a) (Date rec'd by) 1947 JAN 3 (b) Registrar Hilda Williams

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 31, 1946, at 2.50 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull
Intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 24/3

(a) Date of injury 12-31-46 at 12.30 p. M.

(b) Where did injury occur? 234 E. Cross St.

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Fell down steps

23. Signature George L. Merrell M.D. (Medical Examiner.)

Date signed 1-1-47

MCD G47137
15975

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 107

G47137
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-5---6
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) ~~City~~ or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Daniel Murphy

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1853

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 93 | 8 | 10 | ..... hr. ..... min. |

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Daniel Murphy
13. Birthplace Ireland

MOTHER
14. Maiden Name Nore Tuigh
15. Birthplace Ireland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 1/3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Loreauville Rd

18 (a) Funeral director J. D. Taylor & Sons
(b) Address 1918 Bryden Rd.

19 (a) (b)
(Date rec'd by registrar) Entry for Williams Mgr.

JAN 3 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 1946, at 5:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1928 to Dec. 30 1946, and that I last saw him alive on Dec. 30 1946.

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia | 2 days |
| Due to | |
| Due to | |
| Other Conditions Senescent a Arteriosclerosis | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.
Address Balt. City Hosp. Date signed 12/31/46

X

G47138

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 74B

Registered No. G47138

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address North Broadway.
(c) Hospital or institution:
Church Home & Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 22 days.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Cook
(c) City or town Chicago
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ambassador Hotel
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Martin C Schenck.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mrs Eliz Schenck.
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Sept 2, 1876.

8. AGE: Years 70 | Months 3 4 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Engineer.
11. Industry or business Mine Research Co.

FATHER
12. Name Marx Schenck
13. Birthplace Germany

MOTHER
14. Maiden Name Laura Finstone
15. Birthplace Baltimore

16 (a) Informant Mrs Elizabeth Schenck.
(b) Address 20 Bowdoin West Chicago.

17 Rem. & Burial Date thereof 1/3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~cemetery~~ Rose Hill
Location Chicago, Ill.

18 (a) Funeral director Rudd Undertaking Co.
(b) Address 1902 Eastern Place

19 (a) ____ (b) ____
(Date rec'd by registrar) Registrar

JN 9 1947 Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2, 1947, at 1 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11 1946, to Jan 2 1947, and that I last saw h[im] alive on Jan 2 1947

Immediate cause of death Leukemia Leukemia Splenomegaly. — Duration 5 yrs 5 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: splenomegaly.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Buchanan M. D.
Address Church Home & Hosp. Date signed Jan 4, 47

G47139

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47139 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1420 Mountmon ct
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1420 Mountmon ct
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Chaney

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Sylvester Chaney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 29, 1878

8. AGE: Years 68 | Months 10 | Days 2 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name Fredrick Berry

13. Birthplace Md

MOTHER 14. Maiden Name Susan Berry

15. Birthplace Md

16 (a) Informant Mrs Thomas Chaney

(b) Address 1420 Mountmon St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-47 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director George A. Kelson

(b) Address 1303 Presstmann St

19 (a) Filed JAN 3 1947 (b) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1946, at 11 30 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1946 to Dec 31 1946, and that I last saw h[illegible] alive on Dec. 31 1946

| Immediate cause of death | Duration |
|---|---|
| Uremia | Twenty |
| Due to Hypertension | |
| Due to Cerebral Vascular Disease | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.

Address [illegible] Date signed 1/3/47

X

G47140

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 830

G47140 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2832 Dillon St.
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2832 Dillon St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME James Siegmund

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | white | married |

6 (b) Name of husband or wife Martha Siegmund
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 6 | 28 | hr. min. |

9. Birthplace Cambridge Md.
(Town, county, and state)
10. Usual Occupation Dock foreman
11. Industry or business

FATHER
12. Name John Siegmund
13. Birthplace ?

MOTHER
14. Maiden Name Rose Halminski
15. Birthplace ?

16 (a) Informant Martha Siegmund
(b) Address 2832 Dillon St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/47 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cem
Location Dundalk Ave
18 (a) Funeral director John J. Duda
(b) Address 2472 Hudson St.

JAN 3 1947
(Date rec'd by registrar)

(b) Hamilton Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 1 1947, at 6 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 30 1946 to Jan. 1 1947, and that I last saw him alive on Dec. 30 1946.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | Days Week |
| Due to Unknown | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Major findings: None
Of operations
Of autopsy None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. A. Rosenblatt M. D.
Address 318 O'Donnell St. Date signed 1-2-47

VS 3

X

7141

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13 B

G47141 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1840 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a). FULL NAME** Lois Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Roy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-19-26

8. AGE: Years 19 | Months 0 | Days 12 | If less than one day: hr. min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation Housemaid

11. Industry or business

FATHER 12. Name Albert James

13. Birthplace S. C.

MOTHER 14. Maiden Name Beatrice Planter

15. Birthplace S. C.

16 (a) Informant Mrs. Beatrice Jones

(b) Address 1840 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 3, 1947 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park

Location Baltimore Co. Md.

18 (a) Funeral director Mary Geo. A. Holland

(b) Address 1631 Druid Hill Ave.

JAN 3 1947 (Date rec'd by Local Registrar) (b) Baltimore, Md. (Registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 31 1946, at 12 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 9 1946 to Dec 31 1946 and that I last saw her alive on Dec 31 1946

Immediate cause of death: Miliary Tuberculosis — Duration: 2 9 mo

Due to

Due to

Other Conditions: Tuberculous otitis media — new

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: miliary tuberculosis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E. Mason M. D.

Address Johns Hopkins Hosp. Date signed 31 Dec 46

X

1 - Transcript

G47142

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

G47142 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5005 Park Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5005 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Norman L White

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-07-23[illegible]

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lola J. Todd

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14 1886

8. AGE: Years 60 | Months 6 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Ass't Storekeeper

11. Industry or business M. L. Chemical Co

FATHER 12. Name Milton White

13. Birthplace Barnesville Md

MOTHER 14. Maiden Name Lydia Bell

15. Birthplace Baltimore Md

16 (a) Informant Mrs. Lola J. White

(b) Address 5005 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-47 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cemetery

Location Pikesville Md

18 (a) Funeral director George Byers

(b) Address 5005 Park Heights Ave

19 (a) (Date received) JAN 3 1947 (Registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 1 1947, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1946 to Jan 1 1947 and that I last saw him alive on Dec 30 1946.

| Immediate cause of death | Duration |
|---|---|
| Cerebral hemorrhage | 1 day |
| Due to Arterio-sclerosis | |
| Hypertension | 4 yrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norman L. Todd M. D.

Address 2108 St Paul St Date signed 1/1/47

G47143

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 83a

Registered No. G47143

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2813 Frederick Ave.
(c) Hospital or institution: 20

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2813 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) **FULL NAME** HENRY TARUN

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Marie T. Tarun
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) March 25, 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 9 | 5 | ..... hr. ..... min. |

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation (retired)
11. Industry or business

FATHER
12. Name William Tarun
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Shilling
15. Birthplace Germany

16 (a) Informant Mrs. Thomas E. Boyle
(b) Address 4500 Leeds Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 Jan. 47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Maryland

18 (a) Funeral director F. B. Wisheart & Sons
(b) Address 1300 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Lewington-Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Dec. 46 19 ..., at 9:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 47 to 12/30 19 46, and that I last saw him alive on 12/30 19 46

Immediate cause of death Cerebral Hemorrhage
" "
Due to Renal Artero-Sclerosis & Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
12/30/46 from 1942
5 yrs

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elliot W. Johnson M. D.
Address Frederick Ave Date signed 3 Jan 47

JAN 3 150 1947

Dr. E. W. Johnson.

G47144

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G47144

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1430 Fillmore Street
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 1430 Fillmore Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

**3 (a) FULL NAME** LEVENIA L. BRYAN

3 (b) If veteran, name war ********
3 (c) Social Security Account No. *********

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife William A. Bryan
6 (c) If alive, give age Do years

7. Birth date of deceased (mo., day, yr.) 6 / 4 / 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 6 | 27 | ********** hr. ********** min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Lawrence King
13. Birthplace Maryland

MOTHER
14. Maiden Name Unkown
15. Birthplace Maryland

16 (a) Informant Mrs. William E. Bryan (son)
(b) Address 1430 Fillmore Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4 Jan. 47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director J. B. Wakefield & Son
(b) Address 1300 Eutaw Place 17

19 (a) (Date rec'd by registrar) Huddington Williams, M.D.

JAN 3 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH 31 December 1946, at 6.A M

21. I certify that death occurred on the date above stated; that I attended deceased from 26 Dec 1946 to 31 Dec 1946, and that I last saw her alive on 31 Dec 1946.

| Immediate cause of death | Duration |
|---|---|
| Heart Failure | 3 hrs |
| Due to Myocardial Insufficiency | 2 yrs |
| + Arteriosclerosis | 3 yrs |
| Due to | |
| Other Conditions Senility | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Guy M. Zimmerman M. D.
Address 2858 Harford Rd. Date signed 2 Jan. 47

Dr. Zimmerman X

G47145

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1312

Registered No. G47145

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3312 Rosekemp Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3312 Rosekemp Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Margaret E Kaufderer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 25 1861

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 85 | 4 | 8 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation N. W.

11. Industry or business

FATHER
12. Name Andrew Kaufderer
13. Birthplace Balto Md

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Henry E. Kaufderer
(b) Address 3312 Rosekemp Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 4 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director Wm. Jno. John H. Teufel & Son
(b) Address 5311 Edmondson Ave

19 (a) (Date rec'd) 1947 (b) Huntington Williams, M.D.

JAN 3

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 2 1947, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1946 to Jan 2 1947, and that I last saw h[illegible] alive on Jan 2 1947.

| Immediate cause of death | Duration |
|---|---|
| (a) Uremia | 2 days |
| Due to (b) Chronic Parenchymatous Nephritis | 4 years |
| Due to (c) | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: No

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide? No
(b) Date of occurrence at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury? None

23. Signature L. L. Cloudy M.D.
Address 5706 Harford Rd Date signed 1-2-47

X

G47146

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 30 c

Registered No. G47146

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 wks.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Pa. (b) County
(c) City or town Hanover (If outside city or town limits, write RURAL and give town)
(d) Street No. 201 E. Middle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Walter E. Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, Married, Widowed, or divorced.

6 (b) Name of husband or wife: Anna Baker
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Jan 3, 1947

8. AGE: Years 52 | Months 5 | Days 3 | If less than one day: hr. 4 | 28 | 1894 min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Window trimmer

11. Industry or business

FATHER 12. Name Daniel Baker
13. Birthplace York Co. Pa.

MOTHER 14. Maiden Name Lillian Ruth
15. Birthplace York Co. Pa.

16 (a) Informant Mrs. Anna Baker
(b) Address Hanover Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 6 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Hanover, Pa.

18 (a) Funeral director W. G. Heiges
(b) Address Hanover Pa.

19 (a) JAN 3 (Date received by Registrar) (b) 1947 Hampton Hollinsworth, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3- 1947, at 2 01 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-23 1946 to 1-3 1947, and that I last saw him alive on 1-2 1947.

| Immediate cause of death | Duration |
|---|---|
| Intraventricular Hemorrhage | |
| Due to Hypoprothrombinemia | |
| Due to Dicumarol & Malaria therapy for C.V.S. Lues complicated by Thrombocytopenia | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Intraventricular Hem.
of autopsy: Intraventricular Hem.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. A. Shallenberger M. D.
Address University Hospital Date signed 1-3-47

VS 150

X

G47147

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 B

Registered No. G47147

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 509 West St. W.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 509 West St. W.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mazie Smith

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Jerome Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1898

8. AGE: Years 48 | Months - | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md. (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Howard Dorsey

13. Birthplace Md.

MOTHER 14. Maiden Name Louise Howard

15. Birthplace Md.

16 (a) Informant Dorothy Williams

(b) Address 509 West St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3, 1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion Cem.

Location

18 (a) Funeral director Mrs Katie R Williams

(b) Address 322 N Schroeder St.

19 JAN 3 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1946, at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/4 1946 to 12/29 1946 and that I last saw h[illegible] alive on 12/29 1946

Immediate cause of death Carcinoma Stomach — Duration: 2 mo

Due to — Duration: 7 d

Due to — Duration: V

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible] M.D.

Address 1 W Pratt Date signed 1/2/47

V S 150

7148

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. 647148

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 726 Bradley St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(3) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 726 Bradley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lillian Lillie Saunders

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Benjamin Saunders

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1886

8. AGE: Years 66 58 | Months - | Days 15 | If less than one day hr. min.

9. Birthplace Philadelphia Pa.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Turner

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Martha Williams

15. Birthplace Balto Md.

16 (a) Informant Benjamin Saunders

(b) Address 726 Bradley St

17 (a) Burial (b) Date thereof Jan 3 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Zion Cem.

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N Schroeder St.

19 (a) JAN 3 1947 (b) Huntington Williams
(Filed by registrar) (Signature of registrar)

V S 190

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec. 30 19 46, at 6 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 12-20 19 46, to 12-30 19 46, and that I last saw h alive on 12-30 19 46.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature M. D.
Address Date signed

X

47149 505731

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46F

G47149 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 46

(d) Length of stay in hospital or inst. (yrs., mos., days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 S. Pelinton St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Kramer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Mary Kramer
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) 9-2-72

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 4 | - | hr. min. |

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Contractor
11. Industry or business

FATHER 12. Name James Kramer
13. Birthplace Md

MOTHER 14. Maiden Name Patricia Thorn
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 1-6-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Wolfe St.

19 JAN 3 1947 Registered by registrar [illegible] Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-2- 1947, at 8:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3, 1946, to Jan. 2 1947, and that I last saw h alive on Jan 2 1947.

| Immediate cause of death | Duration |
|---|---|
| CARCINOMA OF LIVER - PRIMARY | |
| SITE NOT KNOWN ? PRIMARY | |
| Due to CARCINOMA OF LIVER | |
| Due to | |
| Other Conditions BRONCHOPNEUMONIA TERMINAL | 2 DAYS |

(Include pregnancy within 3 months of death)
Date of operation 12-16-46
Major findings of operation: CARCINOMA OF LIVER
of autopsy: ABOVE

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman F Stephens M. D.
Address Johns Hopkins Hospital Date signed 1-2-47

VS 150

G47150

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1310

Registered No. G47150

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 117 S. Bouldin Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 S. Bouldin Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** HEZEKIAH CHARLES McCLURE

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 213-03-9240

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Anne Elizabeth McClure
6 (c) If alive, give age 68 years
7. Birth date of deceased (mo., day, yr.) Dec. 7, 1875
8. AGE: Years 71 | Months 0 | Days 25 | If less than one day ____ hr. ____ min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Meat Packer
11. Industry or business

FATHER
12. Name John V. McClure
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Grimes
15. Birthplace Maryland

16 (a) Informant Mrs. Anne McClure
(b) Address 117 S. Bouldin Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) JAN 3 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 1 1947, at 3.10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1946 to Jan 1 1947 and that I last saw h[illegible] alive on Dec 31 1946.

Immediate cause of death: Respiratory Failure
Due to: Cerebral Thrombosis
Due to: Arteriosclerotic Cardiovascular Renal disease
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Abercrombie M. D.
Address 60 N. Howard St. Date signed 1/2/47 M. D.

VS 150

G47151

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G47151

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2104 N. Wolfe Street
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2104 N. Wolfe Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** GOTTHARDT GEORGE TREFF

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 213-05-2890

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife: Mary W. Treff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1876

8. AGE: Years 70 | Months 3 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Watchman - Retired
11. Industry or business National Can Co.

FATHER
12. Name Louis Treff
13. Birthplace Germany

MOTHER
14. Maiden Name Minnie W. Zune
15. Birthplace Germany

16 (a) Informant Carlton Treff - son
(b) Address 2104 N. Wolfe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1- 4-48 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER' & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 JAN 3 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

**MEDICAL CERTIFICATION** PM

20. DATE OF DEATH January 1, 1947 at 12.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1940 to Dec. 31 1946 and that I last saw him alive on Dec. 31 1946

Immediate cause of death Coronary occlusion — Duration 5 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Krenzer M.D.
Address 1402 S. Linwood Ave Date signed 1-2-47

VS 150

G47152

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. G47152

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3302 Alto Rd.
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3302 Alto Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** LUTIE MAY DERR

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No. NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: Wm. F. Derr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1878

8. AGE: Years 68 | Months 0 | Days 17 | If less than one day hr. min.

9. Birthplace Westminster, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry C. Keefer
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Keefer
15. Birthplace Md.

16 (a) Informant Mr. William F. Derr
(b) Address 3302 Alto Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/47 (month) (day) (year)
(c) Cemetery or crematory Westminster Cem.
Location

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTO., MD.

19 (a) JAN 3 1947 Registrar's Office, Baltimore, Md.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 2 1947 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Jan 2 1947 and that I last saw her alive on Dec 28 1946

Immediate cause of death: Respiratory failure — Duration:
Due to: Arteriosclerotic cardiovascular renal disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Bloomfield MD
Address 601 N. Howard St. Date signed 1/2/47

X

G47153

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G47153 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Sts
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 Clifton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Edward Bascum Du Val

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. | 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|---|---|
| none | 027-22-3640 | male | white | married |

6 (b) Name of husband or wife (nee Brady) Florine B. Duvall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 11 | 4 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name Richard Duval
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Correll
15. Birthplace Md.

16 (a) Informant Mrs. Edward DuVal
(b) Address 1512 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Balto. Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTO., MD.

19 (a) JAN 3 1947 (Date rec'd by registrar)

Registrar for Baltimore, Md.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 2nd 1947 at 1.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30th 1946 to Jan 2nd 1947 and that I last saw him alive on Jan. 2nd 1947.

Immediate cause of death: Heart failure.
Due to: Arteriosclerotic C.V. Disease & decompensation. — Duration: 3 days
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. E. Gonzalez M.D.
Address Maryland G. Hospital M. D. Date signed 1/2/47

VS 150

(Already by Med. Examiner) E. B.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 181

Registered No. G17154

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address West Baltimore Gen Hosp.
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2317 Ellamont St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** EILEEN THRESE REICHELT

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| None | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Single |

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13, 1928

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 18 | 9 | 19 | hr. min. |

9. Birthplace Balt. (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Arthur C. Reichelt, Jr.
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary C. Thomas
15. Birthplace Phila., Pa.

16 (a) Informant Mr. Arthur C. Reichelt, Jr.
(b) Address 2317 Ellamont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTO., MD.

19 (a) JAN 3 1947 (Date received by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 9 1946 to Jan 2 1947
and that I last saw h alive on Jan 2 1947

Immediate cause of death Cardio Respiratory failure due to Lung Damage and Kidney failure
Due to Extensive 2nd degree burns of body
Due to Sepsis.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 15/7
(a) Accident, suicide, or homicide
(b) Date of occurrence Nov 9 1946 at 1:30 P M
(c) Where did injury occur? Balt. Md. 2317 Ellamont
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? None While at work? Non
(Specify type of place)
(e) Means of injury Matches Extensive 2nd degree Burns

23. Signature E. L. Barrows M. D.
Address W. B. & H. Date signed Jan 3 1947

VS 150

For Dr J. R. Davis, by Howard L. Mercer, M. D. X

G47155 G47155

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 198c

Registered No. 5

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 6402 Arundel Ave. Curtis Bay
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6402- Arundel Cove- Curtis Bay (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** LEONARD SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No. 236-28-1253

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1924

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 22 21 | 10 | 25 | hr. min. |

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation Laborer.
11. Industry or business

**FATHER**
12. Name Jacob A. Smith
13. Birthplace W. Va.

**MOTHER**
14. Maiden Name Martha White
15. Birthplace W. Va.

16 (a) Informant Tedy Smith
(b) Address 1621 Spruce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 4/47 (month) (day) (year)
(c) Cemetery or crematory Westgrn
Location W. Balto & Ardmore

18 (a) Funeral director Martin J. Connors
(b) Address 160 Hollins

JAN 3 1947 Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 1, 1947, at 12p 09 M

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH asphyxiation

Due to Carbon Monoxide.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 2515

(a) Date of injury 1-1-47 at approx. 11 p. M.
(b) Where did injury occur? 6402- Arundel Cove- Curtis Bay
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Bed was on fire

23. Signature Howard J. Andrews M.D. Medical Examiner.
Date signed 1-2-47

VS 151

G47156

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 46E

Registered No. G47156

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Linwood & Towne Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County B. A. Co.
(c) City or town Fearndale Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hammond Ferry Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mildred Brooks

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F. | C. | M. |

6 (b) Name of husband or wife Roland Brooks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 42 | | | hr. min. |

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Andrew J. Reed
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Reed
15. Birthplace Md

16 (a) Informant Mrs Mildred Williams
(b) Address 1723 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3 (Month) (Day) 47 (Year)
(c) Cemetery or crematory Prot. Old. Cem.
Location Brooklyn Md

18 (a) Funeral director Elroy D. Welsh
(b) Address 1017 Brantley Ave

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 3 1947 Huntington Williams, M.D.

VS 130

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1946 at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 28 1946 to Dec. 31 1946 and that I last saw h[illegible] alive on Dec. 31 1946.

| Immediate cause of death | Duration |
|---|---|
| Respiratory & Circulatory failure | |
| Due to generalized carcinoma & toxemia | |
| Due to paralysis of small intestine | |
| Other Conditions Colostomy | |

(Include pregnancy within 3 months of death)

Date of operation 12/3/46
Major findings of operation: Ca. of colon
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. W. Egerton Jr M. D.
Address Univ. Hosp. Date signed 12/31/46

G47157

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1948

Registered No. G47157

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3306 DUPONT AVENUE
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 35 YRS.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town BALTIMORE (15)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3306 DUPONT AVE.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME CEDALIA MAY BENNETT

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F. | W. | MARRIED |

6 (b) Name of husband or wife HARRY W. BENNETT
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) MAY 28, 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 7 | 3 | — hr. — min. |

9. Birthplace DAMASCUS (MONT. CO.) Md.
(Town, County, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business —

FATHER
12. Name JOHN W. MILES
13. Birthplace FREDK CO. Md.

MOTHER
14. Maiden Name ELLEN PHILLIPS
15. Birthplace UNKNOWN

16 (a) Informant HARRY W. BENNETT
(b) Address 3306 DUPONT AVE.

17 (a) BURIAL (b) Date thereof JAN. 4, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location FREDK. AVE. BALTO., CITY

18 (a) Funeral director Walter Brooke Bradley
(b) Address 1922 W. North Avenue

19 (a) (b)
(Date rec'd by reg.) JAN 3 1947 Hampton Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY, 1947, at 6 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to Jan. 1 1947, and that I last saw h.e alive on Dec. 30 1946.

| Immediate cause of death Cachexia | Duration |
|---|---|
| Due to Peritoneal Carcinomatosis | |
| Due to Carcinoma of uterus | |
| Other Conditions Recto vaginal fistula | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James J. Kolodner M. D.
Address 1109 N. Calvert St. Date signed Jan 2, 1947

X

G47158 G47158

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital. 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 160 S. Collins Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** David Harry Dutrow

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Florence L. nee Haynie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 10, 1872

8. AGE: Years 74 | Months 9 | Days 22 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Loudon Pk.

FATHER
12. Name James Dutrow
13. Birthplace Md.

MOTHER
14. Maiden Name —
15. Birthplace Md.

16 (a) Informant Mrs. Florence L. Dutrow
(b) Address 160 S. Collins Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 6/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Kintzel
(b) Address 410 E. Edmondson Ave.

1947 (b) [illegible]
(Date rec'd by registrar)

**MEDICAL CERTIFICATION** 47

**20. DATE OF DEATH** Jan. 2, 1946 at 2.44 P M

21. I certify that I took charge of the remains described above, held an Confirmation Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio - vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 1-2-47

VS 151

G47159 G47159

BALTIMORE CITY HEALTH DEPARTMENT

Med Exam Case **CERTIFICATE OF DEATH** 83a

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 315 N. Central Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** James Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | black | widowed |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | | | hr. min. |

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name James Johnson
13. Birthplace Va

MOTHER
14. Maiden Name Betty Grammer
15. Birthplace

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial Bonnie (b) Date thereof Jan. 2. 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore Md

18 (a) Funeral director Elroy O'Wilson
(b) Address 1510 Orleans St

19 (a) JAN (b)
(Date rec'd by registrar) Registrar

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec - 30 - 1946 at 3 46 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1946 to Dec 30 1946 and that I last saw he alive on Dec 30 1946

| Immediate cause of death | Duration |
|---|---|
| R. cerebral thrombosis | |
| or hemorrhage | |
| Due to | |
| Due to | |
| Other Conditions U | |

(Include pregnancy within 3 months of death)

Date of operation D
Major findings of operation:
of autopsy: D

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature Robert C. Austrian M.D.
Address The Johns Hopkins Hosp Date signed Jan 2 47

For Md State Pathologist, by Howard D. Kneeland M.D. X

G47160 G47160

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland ✓
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: The Seton Institute

(d) Length of stay in hospital or inst. (yrs., mos., or days) 30-6-22 (30yrs)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1220 Bank St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Rose Campbell

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife: none
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 8-25-1893

8. AGE: Years 53 | Months 4 | Days 7 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation housework
11. Industry or business

FATHER
12. Name Michael Campbell
13. Birthplace Ireland

MOTHER
14. Maiden Name Annie Moore
15. Birthplace Ireland

16 (a) Informant The Seton Institute
(b) Address 6420 Reisterstown Road, Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Stewart & Morgan Co.
(b) Address 108 W. Mt. Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 3 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 2nd 1947, at 10:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1921, to Jan 2 1947, and that I last saw h[illegible] alive on Jan 2nd 1947.

Immediate cause of death Life Cerebral Accident — Duration

duration three days.

Due to

Due to

Other Conditions mental deficiency high grade imbecile
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 3316 Gilmor St

X

G47161

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. G47161

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 836 Park Ave
(c) Hospital or institution: at home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 836 Park Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Tripple

3 (b) If veteran, name war none

3 (c) Social Security Account No. 218-09-2756

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife none

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 26 1872

8. AGE: Years 74 | Months 7 | Days 7 | If less than one day: hr. min.

9. Birthplace Talbott Co. Md (Town, county and state)

10. Usual Occupation Insurance

11. Industry or business Penn Mutual

FATHER
12. Name Richard Triffle
13. Birthplace Md.

MOTHER
14. Maiden Name Sophia Kerr Thomas
15. Birthplace Md.

16 (a) Informant Mrs. Maria H. Dobbin (Cousin)
(b) Address 210 Belvidere

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 4-47 (month) (day) (year)
(c) Cemetery or crematory Spring Hill
Location Easton Md.

18 (a) Funeral director Swindell Mowbray Co.
(b) Address 108 W Monument

19 (a) Date rec'd by local reg. JAN 3 1947 (b) Registered by Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2nd 1947, at 8:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1920 to Jan 2 1947, and that I last saw him alive on Dec. 30 1946.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Arterio Sclerosis — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Williams M. D.
Address 108 E. Cabot St. Date signed Jan 3/47

X

G47162

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 194a

G47162 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3314 Carlisle Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) About 28 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3314 Carlisle Avenue
(If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country --------

**3 (a) FULL NAME** Edward D. Prince

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Ethel Leager
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) July 26, 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 5 | 5 | --hr. --min. |

9. Birthplace Dover, Delaware (Town, county, and state)
10. Usual Occupation Advertising & Publicity
11. Industry or business Business

FATHER
12. Name Alexander H. Prince
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary V. Finnegan
15. Birthplace Delaware

16 (a) Informant Mrs. Ethel L. Prince
(b) Address 3314 Carlisle Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/47 (month) (day) (year)
(c) Cemetery or crematory Loraine Memorial
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) ---- (Date rec'd by Local Reg.) (b) ----

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1st 1947, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 30 1946 to Jan. 1 1947 and that I last saw him alive on Jan. 1st 1947

Immediate cause of death: 1) Coronary Thrombosis — Duration: 3 Days
Due to
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emil L. Blumberg M. D.
Address 4108 Liberty Hts. Date signed 1/3/47

X

G47163

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 93D

G47163 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1458 Patapsco
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1458 Patapsco
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ELIZABETH SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife John J. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1871

8. AGE: Years 75 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER
12. Name Joseph Hartenstein
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Frank W. Smith
(b) Address 1458 Patapsco St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 JAN 3 1947 (Rec'd by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/1/47 19 , at 9:35 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Ward M.D.
Medical Examiner.
Date signed 1/3/47

VS 151

G47161

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 95c

G47164 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 6318 Hudson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6318 Hudson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Sadie Jane Wawrzyniak

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. 212-09-7384 |
|---|---|

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Alexander Wawrzyniak
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 6, 1897

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 49 | 1 | 26 | hr. min. |

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Inspectress
11. Industry or business Crosse & Blackwell

FATHER
12. Name William McLaughlin
13. Birthplace Ireland

MOTHER
14. Maiden Name Sara Surjay
15. Birthplace Baltimore Md.

16 (a) Informant Alexander Wawrzyniak (husband)
(b) Address 6318 Hudson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 4 1947 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Eastern Ave Baltimore Md.

18 (a) Funeral director Frank Wallace
(b) Address 52 N. Morley St.

19 (a) (b)
D. rec'd (Registrar) Huntington Williams, M.D.
JAN 3 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1947 at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1946 to Jan 2 1947 and that I last saw h[illegible] alive on Jan 2 1947

| Immediate cause of death | Duration |
|---|---|
| (a) | |
| Due to (b) Cerebral Thrombosis | |
| Due to (c) Coronary Heart Failure (Congestive) | |
| Due to (d) Bronchial & Cardiac Asthma | |

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Stevens M.D.
Address 3400 Edmondson Ave Date signed 1/2/47

G17165

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

G17165 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 405 Park Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 405 Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Sarah J. McCall

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 5 | | hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Patrick J. McCall
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary A. McCloskey
15. Birthplace Ireland

16 (a) Informant Mrs Fannie O'Donnell
(b) Address 405 Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flynn & Flannigan
(b) Address 14 N Eutaw St.

19 Filed JAN 4 1947 Wallace J. Williams M.D.
Registrar
JAN 4 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 1 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30 1946 to Jan. 1. 1947. and that I last saw h alive on Dec 29 1946

Immediate cause of death: Cerebral Hemorrhage — Duration 6 mos
Due to Cerebral Arteriosclerosis — 1 Year
Due to Prostatic Enlargement — 1 yr
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thurman J. White M. D.
Address 532 E 22nd St Date signed 1/3/47

G47166

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G47166 Registered No.

# CERTIFICATE OF DEATH 50

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital,
(d) Length of stay in hospital or inst. (yrs., mos., or days): 62 days
(e) Length of stay in Baltimore (yrs., mos., or days): 62 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: DC (b) County:
(c) City or town: Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 47 Gallatin Street NW
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

**3 (a) FULL NAME:** Cronin, Johanna Mary

3 (b) If veteran, name war:

3 (c) Social Security Account No.: 578-03-1550

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | W | Married |

6 (b) Name of husband or wife: Maurice Cronin
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.): Aug. 9, 1897 ?

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | x4 | 25 | hr. min. |

9. Birthplace: Limerick, Ireland
(Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: James Corbett
13. Birthplace: Limerick, Ireland

MOTHER
14. Maiden Name: Mary Collins
15. Birthplace: Limerick, Ireland

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (b) Date thereof: 1/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet
Location: Wash. D.C.

18 (a) Funeral director: John A. Gorman
(b) Address: 3600 E. Baltimore St.

JAN 4 1947 (Date rec'd by Registrar) Huntington Williamsville

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Jan. 3 1947, at 3 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3 1946 to Jan. 3 1947, and that I last saw h. alive on Jan. 3 1947.

| | Duration |
|---|---|
| Immediate cause of death: Liver metastasis | 3 mos. |
| Due to: Adenocarcinoma of breast | 3 yrs. |
| Due to: | |
| Other Conditions: Metastasis to bone | 1½ yrs. |

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: None done

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:
23. Signature: Louis S. Santomieri
Address: Asst. Surgeon (R) Date signed: 1/3/47

VS 150

X

47167

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 58c

G47167 Registered No.

506852

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Maryland Farms (If outside city or town limits, write RURAL and give town)
(d) Street No. Stevenson TRAYFORD (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James. Ambrose.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Mary E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-14-07

8. AGE: Years 39 | Months 8 | Days 29 | If less than one day hr. min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation Butler

11. Industry or business

FATHER
12. Name Alfred Ambrose.
13. Birthplace England

MOTHER
14. Maiden Name Alice Norner
15. Birthplace England.

16 (a) Informant Relative.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 4-1947 (month) (day) (year)
(c) Cemetery or crematory Quiet Ridge
Location Parkville Maryland

18 (a) Funeral director Francis H. Purcell
(b) Address Parkville, Md.

19 (a) Filed [illegible] 1947 (b) Registered by [illegible]

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1 1947 at 2. A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 24 1946 to Jan 1 1947. and that I last saw him alive on Jan. 1 1947.

Immediate cause of death: ACUTE RHEUMATIC MYOCARDITIS — Duration: 1 WEEK

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: ADEKS

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas S. Stephens M. D.
Address Johns Hopkins Hospital Date signed 1-1-47

VS 150

47168

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. G47168

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1605 Baselburn Ct
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Baselburn Ct
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lillie Mae Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-14884

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | colored | Widowed |

6 (b) Name of husband or wife Isaac M. Brooks
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1-24-1905

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 41 | 11 | 7 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business Vincent Upholstery Co

FATHER
12. Name Harry Thomas
13. Birthplace Unknown

MOTHER
14. Maiden Name Elizabeth Payler
15. Birthplace Baltimore Md

16 (a) Informant Emma Francis
(b) Address 1605 Baselburn Ct

17 (a) Burial (b) Date thereof Jan 5-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Westport

18 (a) Funeral director Ve Brooks
(b) Address 1463 N. Carey St

19 Date rec'd by local reg. JAN 4 1947 (b) Registrar Huntington Williams M.D.

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 1-1 1947, at 4 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 12-2 1946 to 1-1 1947 and that I last saw her alive on 12-31 1946.

| Immediate cause of death | Duration |
|---|---|
| Nephritis | unknown |
| Due to | |
| Due to | |
| Other Conditions Hypertension | unknown |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature Frank A. Saunders M. D.
Address 1029 N. Stricker Date signed 1-1-47

X

G47169

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94 B

Registered No. G47169

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3215 Dorchester Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 11
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3215 Dorchester Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ESTELLE HARTZELL MARSHALL

3 (b) If veteran, name war: --

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Wm. E. Marshall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 3, 1870

8. AGE: Years 76 | Months 9 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John W. Hartzell
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Amanda
15. Birthplace Carroll Co., Md.

16 (a) Informant Mr. Carl W. Euker
(b) Address 5800 Narcissus Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (Date received by reg.) JAN 4 1947 Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 2, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Jan 2 1947, and that I last saw her alive on Jan 2 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardiac Asthma | 2 hrs |
| Due to Angina Pectoris | 1 da. |
| Due to Hypertension Arteriosclerosis | 3 yrs. 3 yrs |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. W. Euker M. D.
Address 1202 St Paul St Date signed Jan 3/47

VS 150

G47170

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 178a

Registered No. G47170

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 ds
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 West North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM C. KOEHNLEIN

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 213-18-7126

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mamie P. Koehnlein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1889

8. AGE: Years 57 | Months 4 | Days 1 | If less than one day hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: watchman

11. Industry or business

12. Name: William Koehnlein

13. Birthplace: Baltimore, Md.

14. Maiden Name: Sophie Reiling

15. Birthplace: Md.

16 (a) Informant: Mr. John F. Koehnlein

(b) Address: 5213 Wilton Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/47 (month) (day) (year)

(c) Cemetery or crematory: Loudon Pk. Cem.

Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS

(b) Address: BALTO., MD.

19 (c) JAN 4 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2/47 19 4:53 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to carbon monoxide poisoning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/2/47 at 2:00 P. M.
(b) Where did injury occur? Home
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Turned on gas heater.

23. Signature John F. Haase M.D. Medical Examiner.

Date signed 1/3/47

VS 151

G47171

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

186a

G47171 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Death
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town East (If outside city or town limits, write RURAL and give town)
(d) Street No. 4230 - Marlyn Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John FEIT

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Theresa C. Feit

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 9 - 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 11 | 23 | hr. min. |

9. Birthplace Baltimore Co. (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

12. Name John Feit

13. Birthplace Balto. Co.

14. Maiden Name Johnna Unk.

15. Birthplace Unknown

16 (a) Informant Mrs. Eliz. Hendrick

(b) Address 4233 Marlyn Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/47 (month) (day) (year)

(c) Cemetery or crematory Moreland Park

Location Taylor Ave. Balto. Co.

18 (a) Funeral director John G. Connelly

(b) Address 411 Eastern Ave. Balto.

JAN 4 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 1, 1947, at 4:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Fractured neck

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 1/1/47 at about - 3:00 a. M.

(b) Where did injury occur? 4232 - Marlyn Ave Essex

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Fell down steps

23. Signature George L. Merrill M.D. Medical Examiner.

Date signed 1/6/47

VS 151

G47172

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 170c

G47172 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1022- N. Gay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** GUS ROBERTS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Francisca Roberts

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/16/1899

8. AGE: Years 47 | Months 6 | Days 6 | If less than one day hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Francisca Roberts
(b) Address 1022 N. Gay st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 4, 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn, Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1510 Hildan St

JAN 4 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21, 1946, at 6.45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial hemorrhage

Due to Fractures of both tibial bones

Due to Laceration of scalp.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 10/2

(a) Date of injury 12-21-46 at 5.50 p. M.
(b) Where did injury occur? Monument & Ensor Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Pediastrian-struck by auto

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 12-21-46

VS 151

G47173

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13 1a

Registered No. G47173

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 413 Maryland ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 413 Maryland ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Bessie A Rhule

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife John H. Rhule
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1, 1862

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 84 | 5 | 2 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business None

FATHER
12. Name James Smith
13. Birthplace England

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant John A Rhule
(b) Address 183 Mt Vernon St. Ridgefield Park N. J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/47 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 317 E Pratt St

JAN 4 1947 (Date rec'd by registrar) Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1947, at 5 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 18 1946, to June 3 1947, and that I last saw h[illegible] alive on June 2 1947.

| Immediate cause of death | Duration |
|---|---|
| Decompensated Mitral Regurgitation | 18 d. |
| Due to Arterio Sclerosis | 18 d. |
| Hypertension | 18 d. |
| Due to Chr. Pancreatitis Hyperplasia | 18 d. |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. F. A. Stevens M. D.
Address 2878 Harford Rd Date signed 1-3-46

VS 150

17174

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G17174

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3611 Ednor Rd
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3611 Ednor Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles W. Pegg

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Matilda A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23rd 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 3 | 10 | hr. min. |

9. Birthplace London England
(Town, county, and state)
10. Usual Occupation Importer
11. Industry or business Tea

FATHER
12. Name John Thomas Pegg
13. Birthplace England

MOTHER
14. Maiden Name Mary Sweet
15. Birthplace England

16 (a) Informant Matilda Pegg
(b) Address 3611 Ednor Rd.

17 (a) Removal (b) Date thereof 1/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Evergreen
Location Brooklyn N.Y.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

JAN 4 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3rd 1947, at 10:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to 3 Jan 1947, and that I last saw him alive on 3 Jan 1947

| Immediate cause of death | Duration |
|---|---|
| Coronary thrombosis | 5 yrs |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Z. Vance Hooper
Address 55 E. 84th St. Date signed 3 Jan 47 M.D.

VS 150

Z. VANCE HOOPER, M.D.

17175

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46E

Registered No. G17175

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1701 N. Ellamont St.
(c) Hospital or institution:
Feinblatt Nursing Home. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Ellamont St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** BERTHA BLUM.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Albert Blum
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1858.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 88 | | | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Moses Schloss,
13. Birthplace Germany.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Unknown.

16 (a) Informant Mr. Lawrence Blum,
(b) Address 1926 W. North Ave.

17 (a) Burial (b) Date thereof 1.5.47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Levine & Son
(b) Address 1009 Eutaw Place.

19 JAN 4 1947 (b)
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 2nd. 1947, at 9 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1946 to Jan 2 1947.
and that I last saw HER alive on Jan 2 1947.

Immediate cause of death
Carcinoma of small intestine
Due to Senility

| Duration |
|---|
| |
| |
| |
| |
| |

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Louis T. Levy
Address 1844 W. North Ave. Date signed 1/9/47 M. D.

VS 150

17976 Rachel 2901 Edmondson Ave
File 342.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G47376

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2738 Edmondson Ave
(c) Hospital or institution: 14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2738 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jane Shanks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wm. J. B. Shanks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22 1864

8. AGE: Years 82 | Months 6 | Days 12 | If less than one day hr. min.

9. Birthplace Lancaster Pa.
(Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name John Dilhouse
13. Birthplace Lancaster Pa.

MOTHER
14. Maiden Name Mary McDermit
15. Birthplace Ireland.

16 (a) Informant Wm. J. B. Shanks
(b) Address 2738 Edmondson Ave

17 (a) Burial (b) Date thereof Jan. 6 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Mance C. Syfer
(b) Address 1600 W. North Ave

(c) Filed 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 3

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3 1947, at 5A M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1946 to Jan 3 1947, and that I last saw him alive on Jan 0 1947.

Immediate cause of death Pneumonia, due or as a consequence of Arteriosclerosis | Duration 1 week

Due to Generalized arteriosclerosis | years

Due to

Other Conditions Cerebral hemorrhage | 4 months
Hemiplegia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Mitchell M. D.
Address 2901 Edmondson Ave. Date signed Jan 4 1947

21 2 L06304

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

107

Registered No. G47377

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 10
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 129 S. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Willie Parker

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | Sep. |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | 10 | 27 | hr. min. |

9. Birthplace Ala.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Junie Parker
13. Birthplace Ala.

MOTHER
14. Maiden Name Gertrude Wilson
15. Birthplace Ala.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Jan 4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Ave.
Location A A County Md

18 (a) Funeral director Mrs R.D. Elliott Dft
(b) Address 1229 N. Carrollton Ave

19 (a) Filed 1947 (b) Registrar Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1 1947, 10.05AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22 1946, to Jan. 1 1947, and that I last saw h. im alive on Jan. 1 1947.

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia | 2 wks |
| Due to | |
| Due to | |
| Other Conditions | |
| Pneumonemia | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J C Robinson Jr. M. D.
Address Balto City Hosp Date signed 1/3/47

X

G47178

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 B

Registered No. G47178

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-O-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 919 E. Madison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Junius Perkins
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Minnie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1900

8. AGE: Years 46 | Months 2 | Days 18 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

12. Name Unknown
13. Birthplace
14. Maiden Name Unknown
15. Birthplace

16. (a) Informant Minnie Perkins
(b) Address 919 Madison St

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan 4/47 (month) (day) (year)
(c) Cemetery or crematory
Location La Crosse Va.

18. (a) Funeral director Mrs. Peter A. Elliott & Daughter
(b) Address 1129 N. Carlisle St.
(c) JAN 4 1947 Huntington Williams, M.D. Registrar
(Date received by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 2, 1947, at 12 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Enquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of Stomach with metastases

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 1-2-47

VS 151

47179

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G47179

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1020 Wilmer Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 Wilmer Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agness Pate

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) — — 1908

8. AGE: Years 38 48 | Months — | Days — | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation House work

11. Industry or business

FATHER
12. Name Charles Sye
13. Birthplace Md

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant John Marshall
(b) Address 1020 Wilmer Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location Baltimore

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave

19 (a) (Date rec'd) JAN 4 1947 (b) [illegible] Williamson

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 1946, at 7.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 31 1946 to Dec 31 1946 and that I last saw h[illegible] alive on Dec 31 1946

| Immediate cause of death | Duration |
|---|---|
| (a) Coronary Heart Failure | 10 Hr |
| Due to (b) Arteriosclerotic Heart Disease | 6 Months |
| Due to (c) | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address [illegible] Date signed 1-2-47 M. D.

G47180

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G47180

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Carroll
(c) City or town Hampstead
(If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Emma R Ruby

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | married |

6 (b) Name of husband or wife George A. Ruby

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 1 | 7 | hr. min. |

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Andrew Shaffer
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca Snyder
15. Birthplace Md.

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 6-1947 (month) (day) (year)
(c) Cemetery or crematory Hampstead
Location Hampstead, Md.

18 (a) Funeral director Edward C Lipton
(b) Address Hampstead, Md.

19 (c) Filed by Registrar JAN 4 1947 Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3 1947, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-24 1946 to 1-3 1947 and that I last saw h CK alive on 1-3 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardiac Failure | |
| Due to Arteriosclerotic C-V Disease. | |
| Due to | |
| Other Conditions Diabetes Mellitus | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J Brookman M. D.
Address Univ. Hosp. Date signed 1-3-47

93D

347181 BC# SASS

BALTIMORE CITY HEALTH DEPARTMENT

G62844 CERTIFICATE OF DEATH ✓ 161c

Registered No. G47181

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Anne Arundel
(c) City or town Glen Burnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. 406 1st Ave. S.W.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stephen Sass (Middle Name — Thomas)

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1946

8. AGE: Years | Months: 1 | Days: 16 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER — 12. Name Darnel E. Sass
13. Birthplace Bloomfield, No. 6

MOTHER — 14. Maiden Name Constance A. McCann
15. Birthplace Everett, Mass.

16 (a) Informant Mrs. Darnel E. Sass
(b) Address 406-1st Ave, S.W. Glen Burnie Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 5 1947 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie

18 (a) Funeral director Thomas W. Singleton, Glen Burnie
(b) Address Glen Burnie
Registrar Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-3-47 19 at 6:12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3 1947 to 1-3 1947, and that I last saw h.i.2m. alive on 1-3 1947.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to acute toxemia | |
| Antecedent Contraction | |
| Due to hemorrhage | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
M. D.
Address Univ. Hosp. Date signed 1-4-47

1947

VS 150

X

G47182

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 94a S 47182

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 616 N. Streeper St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 616 N. Streeper St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Vanko

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| female | white | widowed |

6 (b) Name of husband or ~~wife~~ John Vanko
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 yrs. | 4 | 19 | hr. min. |

9. Birthplace Czechoslovakia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Alois Marshalek
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Anna Kvicala
15. Birthplace Czechoslovakia

16 (a) Informant Mr. August Richards
(b) Address 616 N. Streeper St.,

17 (a) Burial (b) Date thereof 1/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) Date rec'd by Registrar JAN 5 1947 (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 3 1947, at 7:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/30 1936, to Jan 3 1947 and that I last saw her alive on Jan 1 1947.

| Immediate cause of death | Duration |
|---|---|
| a Arteriosclerosis - generalized | 3 years |
| Coronary artery disease | |
| Due to Hypertension | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis F. Klemes M. D.
Address 2238 E. Monument Date signed 1/3/47

VS 150

G47183

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1318

G47183 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3034 Clifton Park Terrace
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Clark, Thomas Michael

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| WW2 | --- |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Divorced |

6 (b) Name of husband or wife ?
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1914

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 32 | 4 | 29 | hr. min. |

9. Birthplace Balto, Md.
(Town, county, and state)
10. Usual Occupation Lithographer worker
11. Industry or business

FATHER
12. Name Robert J. Clark
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Mary R. Melvin
15. Birthplace Balto, Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof Jan. 7, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ U.S.National
Location Frederick Rd. Baltimcre, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

Date rec'd 1947 Registrar Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 3 1947, at 3:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 21 1946 to Jan. 3 1947.
and that I last saw him alive on Jan. 3 1947.

| Immediate cause of death | Duration |
|---|---|
| Uremia | 2 wks. |
| Pericarditis | 2 wks. |
| Due to Chronic glomerulonephritis with renal insufficiency | 1 yr. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy None done

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M.D.
Address Clinical Director Date signed 1/3/47

VS 150

X

G47184

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 107

G47184 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2622 Grogan Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2622 Grogan Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** SALLY ELIZABETH CRAIG

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| female | white | widowed |

6 (b) Name of husband or wife John Craig
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1862

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 84 | - | 21 | hr. min. |

9. Birthplace Amherst, Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Hiram McGinnis
13. Birthplace Ireland

MOTHER
14. Maiden Name Emma Burford
15. Birthplace Virginia

16 (a) Informant Mrs. Helen McG. Reeves
(b) Address 823 Brunswick Road

17 (a) Ship - Burial (Burial, cremation, or removal) Date thereof 1/6/47 (month) (day) (year)
(c) Cemetery or crematory
Location Shipman, Virginia

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) (Date received by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 4 1947, at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 9 1946 to Jan. 4 1947, and that I last saw h[illegible] alive on Jan 3 1947.

Immediate cause of death: Arteriosclerosis generalized
Hemiplegia - Pneumonia
Duration: 2 weeks
Due to: Bronchitis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lorna F. Klimas M. D.
Address 2623 E. Monument Date signed 1/4/47

Washington Williams, M.D. Registrar

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G47185

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 95B

G47185 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland Sinai Hospital
(b) Street address Monument & Rutland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4007 Boarman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Chesler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Reuben

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1901

8. AGE: Years 45 | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace Philadelphia Pa (Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER
12. Name David Zucker
13. Birthplace Russia

MOTHER
14. Maiden Name Ethel Hozen
15. Birthplace Russia

16 (a) Informant Reuben Chesler
(b) Address 4007 Boarman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 5, 1947 (month) (day) (year)
(c) Cemetery or crematory Aitz Chaim Cong
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) 1947 (Date) (b) [illegible] (District of registration) [illegible] Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 3, 1947, at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 31, 1946 to Jan 3 1947, and that I last saw her alive on Jan 3 1947.

Immediate cause of death Respiratory failure — Duration

Due to Bronchopneumonia

Due to

Other Conditions Rheumatic heart dz: decompensated

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sidney Green M. D.
Address Sinai Hospital Date signed 1/3/47

107

VS 150

G47186

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 166

G47186 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. b
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 Orleans St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Stein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Late Eli

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years 39 | Months | Days | If less than one day hr. min.
40

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Grocer Business

12. Name Benjamin Fox

13. Birthplace Russia

14. Maiden Name Mary ?

15. Birthplace Russia

16 (a) Informant Sarah Levin

16 (b) Address 2216 E Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 5, 1947 (month) (day) (year)

17 (c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros

18 (b) Address 1124-1126 W North Ave

19 (a) 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

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## MEDICAL CERTIFICATION

20. DATE OF DEATH January 4 1947, at 10 A. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 1-3-47

(a) Date of injury Between 11 PM & 630 am 1/4/47

(b) Where did injury occur? 2109 Orleans St

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Firearms

23. Signature Howard J. Madden M.D. Medical Examiner.

Date signed 1-4-47

G47187

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47187 Registered No. 832

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2017 Madison Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2017 Madison Ave. (If rural give location)
(e) Citizen of foreign country? no. (Yes or No) If yes, name country

3 (a) FULL NAME Emma Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1880

8. AGE: Years 66 Months 2 Days If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Raymond Ford

13. Birthplace Chew Virginia

MOTHER 14. Maiden Name ?

15. Birthplace Crew Va.

16 (a) Informant Mary Fairfax

(b) Address 2017 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-5-46 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Cedar Hill Md.

18 (a) Funeral director J. Halstead

(b) Address 918 Druid Hill Ave.

19 (a) (Date received by registrar) (b) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 2, 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-28- 1946, to 1-3- 1947 and that I last saw h[illegible] alive on 1-3- 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardiac & Respiratory Failure | |
| Due to Arterial Thrombosis | Indefinite |
| Due to Hemiplegia | 2 |
| Other Conditions Arteriosclerosis | 1 |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ford E. Blum M. D.

Address 2340 Madison Ave Date signed 1-4-47

Washington Williams, M.D.

G47188 G47188

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 8313

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1719 N Wolfe St
(c) Hospital or institution: *****
(d) Length of stay in hospital or inst. (yrs., mos., or days) **
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 N. Wolfe (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Katherine A Nelson.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| **** | **** |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow. |

6 (b) Name of husband or wife Peter Nelson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 3, 1860

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 86 | 2 | 30 | hr. min. |

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name ??? Sode
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs Anne Smith ( Daughter )
(b) Address 1719 N WOLFE St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/47 (month) (day) (year)
(c) Cemetery or crematory Immanuel Cemetery
Location Grinden Lane Baltimore Md

18 (a) Funeral director J Melville Jenkins.
(b) Address 2713 Kirk Ave

1947 (Date rec'd by registrar) Huntington Williams (Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 2 1947, at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1940 to Jan. 2 1947 and that I last saw her alive on Jan. 2 1947

Immediate cause of death Cerebral Thrombosis — Duration 5 Days
Due to Cerebral arteriosclerosis
Due to
Other Conditions Senility
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Wm. H. Grenzer M.D.
Address 1402 E. Lanvale St. Date signed 1-3-47

VS 150

G47189 — Coroner — G47189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1469

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sena Cowen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Simon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Russia

MOTHER 14. Maiden Name Unknown

15. Birthplace Russia

16 (a) Informant Sam Cowen

(b) Address 7016 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-5-47 (month) (day) (year)

(c) Cemetery or crematory

Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E Balto St

19 (a) 1947 (Date rec'd by Registrar) (b) for Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 4, 1947 at 11 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 24 1946 to Jan 4 1947 and that I last saw her alive on Jan 4 1947

Immediate cause of death Surgical Shock — Duration

Due to Hepatic insufficiency

Due to Carcinoma of Head of Pancreas & metastasis to liver

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1/4/47

Major findings of operation: Carcinoma of Head of Pancreas & metastasis to liver

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel D Gehry

Address Sinai Hospital Date signed 1/14/47

VS 150

G47190

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47190 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5014 Belmore Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Simon Kessler

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | White | Married |

6 (b) Name of husband or wife Annie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 77 | | | hr. min. |

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Cecil
13. Birthplace Austria

MOTHER
14. Maiden Name unknown
15. Birthplace Austria

16 (a) Informant Annie Kessler
(b) Address 5014 Belmore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-5-47 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Baltimore St

19 (a) 1947 (Date) (b) [illegible] Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-3-47 19 , at 11:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/30/1946 to 1/3/1947 and that I last saw h[illegible] alive on 1/3/1947.

Immediate cause of death Circulatory failure — Duration

Due to Generalized peritonitis

Due to Mesenteric embolism & thrombosis

Other Conditions Arteriosclerosis Hypertension, Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bertha Kaden M. D.
Address Sinai Hosp. Date signed 1/3/47

Burlington for Williams, M Registrar

VS 150

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G47192

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47192 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 57
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 147 N. Exeter St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Celestine G. Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 189[illegible]

8. AGE: Years 56 | Months 9 | Days 18 | If less than one day hr. min.

9. Birthplace St. Mary's Co., Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER: 12. Name Charles Butler
13. Birthplace Md.

MOTHER: 14. Maiden Name Henrietta Murden
15. Birthplace Md.

16 (a) Informant James Butler
(b) Address 147 N. Exeter St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Ave.

19 (a) (Date rec'd by Registrar) 1947 (b) Christopher Williams M.D. Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec. 31, 1946, at 11.45 P M

**21.** I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Acute edema of lungs
Arteriosclerotic heart disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 1-6-47

X

MS 151

G47192

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 77c

G47192 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1610 - Mc Elderry St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 Mullinaux St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME Frances Johnson

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

(b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1927

8. AGE: Years 19 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

12. Name David Johnson

13. Birthplace North Carolina

14. Maiden Name Blank Patterson

15. Birthplace Baltimore Md

16. (a) Informant David Johnson

(b) Address 1610 Millinaux St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5, 1947 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Park

Location

18. (a) Funeral director Elroy D. Wilson

(b) Address 1510 Orleans St

19. (a) 1947 (Date received by registrar) (b) Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/30 1946, at 10:39 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Alcoholism

Due to

Other Conditions Acute Congestive Cardiac Failure. Acute Pulmonary Edema
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mahoney M.D.
Medical Examiner.
Date signed 12-31-46

G47193

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

G47193 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 107 W Conway St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 W Conway St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** albert ward

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-3345

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Col | married |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | | | hr. min. |

9. Birthplace Farmville va (Town, county, and state)
10. Usual Occupation Saloon
11. Industry or business

FATHER 12. Name Nathen Ward
13. Birthplace Farmville va

MOTHER 14. Maiden Name Anna Ward
15. Birthplace Farmville va

16 (a) Informant Mary Ward
(b) Address 107 W Conway St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.A. Co. Md

18 (a) Funeral director Isaiah R Brown Son
(b) Address 10 E W Montgomery St

19 (a) (Date rec'd by registrar) Huntington Williams

**MEDICAL CERTIFICATION**

20. DATE OF DEATH JAN 1 1947 3:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1946 to Jan 1 1947 and that I last saw h[illegible] alive on Jan 1 1947

Immediate cause of death Respiratory failure — Duration
Due to Myocardial insufficiency
Due to Arteriosclerotic cardio vascular renal disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Shorofsky M.D.
Address 601 N. Monroe St. Date signed 1/7/47 M. D.

vs 1947

G47194

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1131a

G47194 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1320 Greenmount Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1320 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A Fitzgerald

3 (b) If veteran, name war | 3 (c) Social Security Account No. ✓

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Edw. Fitzgerald
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 19 1885

8. AGE: Years 61 | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

12. Name Owen Kelly
13. Birthplace Ireland

14. Maiden Name Mc Shane
15. Birthplace Ireland

16 (a) Informant Miss Kennedy
(b) Address 1320 Greenmount Ave

17 (a) Burial (b) Date thereof Jan. 6. 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rose Wiedefeld
(b) Address 900 Eutaw St

19 (a) Jan 1947 (b) Williams M.D.
(Date received) (Registrar)

Dr. Nomolene

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 1947, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 22 1946 to 12/31 1946 and that I last saw h W alive on 12/31 1946

Immediate cause of death: acute coronary infarction — Duration

Due to: Ch arteriosclerosis

Due to: Ch myocarditis

Other Conditions: Ch interstitial nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Homsteen M. D.
Address 733 Aisquith St Date signed 1/4/47

VS 150

93D

G47195

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47195 Registered No. 1096

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Avenue
(c) Hospital or institution: Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 714 Cator Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Miss Mary A. Larkin ✓

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1865

8. AGE: Years 82 | Months - | Days - | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Retired Schoolteacher

11. Industry or business

FATHER 12. Name Thomas Larkin

13. Birthplace Ireland

MOTHER 14. Maiden Name Bridget Holmes

15. Birthplace Ireland

16 (a) Informant Thomas J. Larkin

(b) Address 714 Cator Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/47 (month) (day) (year)

(c) Cemetery or crematory Mem. Gdns. Location Old Frederick Rd.

18 (a) Funeral director John A. Myers

(b) Address 3600 E. Balto. St.

19 (a) 1947 (Filed by registrar) Thurlington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 1/3/47 at 3:45 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Jan 3 1947 and that I last saw her alive on Jan 3 1947.

Immediate cause of death - Cardiac failure - Pneumonia - Stroke - undetermined | Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature D. W. Whitty M.D.

Address Augie. Hosp. Date signed 1/3/47

VS 150

G47196 G47196

504072

BALTIMORE CITY HEALTH DEPARTMENT X

# CERTIFICATE OF DEATH 516

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. 45 Hawthorne Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Thomas Flaherty.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-6-72

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 10 | 28 | hr. min. |

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Retired Carpenter
11. Industry or business

FATHER
12. Name James Flaherty
13. Birthplace Europe

MOTHER
14. Maiden Name Mary Ann Rynch
15. Birthplace Md.

16 (a) Informant: Rhonda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 1/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Rd.

18 (a) Funeral director John G. Jackson
(b) Address 310 E. Baltimore St.

19 (a) (b) Washington Williams
(Date rec'd by registrar) (Registrar)

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH Jan. 4 1947, at 12.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 6- 1946 to Jan 4 1947. and that I last saw him alive on Jan. 4 1947

| Immediate cause of death | Duration |
|---|---|
| P.O. Complications | |
| Contributing - Peritonitis & Cardiac failure | since 1-2-47 |
| Due to Ca of Prostate | |
| Benign prostatic hypertrophy | 14 yr. |
| Due to | |
| Other Conditions Cachexia, Malnutrition. | |

(Include pregnancy within 3 months of death)
Date of operation 11-13-46 11-29-46 1-2-47
Major findings of operation: Ca of Prostate, Benign prostatic hypertrophy
of autopsy: Not obtained.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roberts. Crompton M.D.
M. D.
Address Johns Hopkins Hosp. Date signed 1-4-46

VS 1947

X

G47197

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

G47197 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2025 Fayette St.
(c) Hospital or institution: Bon Secours Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30d.
(e) Length of stay in Baltimore (yrs., mos., or days) 42 45.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. 16 (If outside city or town limits, write RURAL and name town)
(d) Street No. 2829 Guilford Lake Place (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Anne Routh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-18-04

8. AGE: Years 42 | Months 3 | Days 17 16 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Instructor in Nursing

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace "

MOTHER 14. Maiden Name "
15. Birthplace "

16 (a) Informant "
(b) Address "

17 (a) (Burial, cremation, or removal) (b) Date thereof 1 8 47 (month) (day) (year)
(c) Cemetery or crematory Rose Hill Hagerstown
Location Hagerstown

18 (a) Funeral director C. M. Sutton & Son
(b) Address 905 N. Potomac Hagerstown

19 (a) (Date rec'd by registrar) (b) Registrar

VS 180

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 4 1947, at 9 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-5-1946, to 1-4-1947, and that I last saw her alive on 1-4-1947.

Immediate cause of death: Carcinomatosis. (A) Breast & metastases
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. L. Markley M. D.
Address Bon Secours Hosp. Date signed 1-7-47

X

50 G47198

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 10

G47198 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 713 N. Carrollton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Augusta Holt Washington.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-22-00

8. AGE: Years 46 | Months 2 | Days 10 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Leon Holt
13. Birthplace Md

MOTHER
14. Maiden Name Georgia Johnson
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5, 1947 (month) (day) (year)
(c) Cemetery or crematory Adams Chapel
Location Anne Arundel Co. Md.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) (Date) 1947 (Registrar) Hunter Jones Williams

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-2- 1947, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 30 1946 to Jan 2 1947 and that I last saw h[illegible] alive on Jan 2 1947.

Immediate cause of death Bronchopneumonia
paralysis — Duration: 2 mos 1 wk

Due to Cancer undetermined
Diphtheria — Duration:

Due to Diphtheritic polyneuritis
paralysis — Duration:

Other Conditions Diphtheritic peripheral neuritis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation

of autopsy: Bulbar paralysis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Johns Hopkins Hosp Date signed 1/3/47 (M. D.)

VS 150

G47199

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

G47199 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 338 S Oldhams
(c) Hospital or institution: No

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 338 S Oldhams
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anna Hildebrandt

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Robert Hildebrandt

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Dec 7th 1887

8. AGE: Years 59 | Months - | Days 26 | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name Michael Eberaberger
13. Birthplace Germany

MOTHER
14. Maiden Name Helena Schafer
15. Birthplace Germany

16 (a) Informant Robert Hildebrandt
(b) Address 338 S. Oldhams

17 (a) Burial (b) Date thereof June 5
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Pleasant St

19 (a) (Date received by registrar) Clayton Williams, M.D. Registrar

5 1947

V S 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Jan 2 1947, at 9 30 AM

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec 31 1946, to Jan 2 1946, and that I last saw h[illegible] alive on Dec 30 1946

Immediate cause of death — Duration

Acute Cardiac Failure

Due to

Due to

Other Conditions Carcinoma Rectum
Breast
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23. Signature** Edward A. Flannigan Jr M. D.

Address 3503 Fait Ave Date signed

G47200 BALTIMORE CITY HEALTH DEPARTMENT G47200
CERTIFICATE OF DEATH 1937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5926 Eastern Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5926 Eastern ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Ridgway Schumann

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Helen M Schumann
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Oct 1899

8. AGE: Years 47 | Months 3 | Days | If less than one day ____hr. ____min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Filling Station

11. Industry or business

FATHER 12. Name Richard P. Schumann
13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Fiedebold
15. Birthplace Germany

16 (a) Informant Mrs Helen Schumann
(b) Address 5926 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Eleanor St

19 (a) (Date of) (b) Registrar 5 1947

MEDICAL CERTIFICATION 40

20. DATE OF DEATH January 3 1947, at 1 19 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10 1945 to Jan. 3 1947 and that I last saw h.. alive on Jan 3 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary Obstruction | |
| Due to Arteriosclerosis | |
| & Myocardial degeneration | 1 1/2 yr. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Valentine M. D.
Address 1402 N. Broadway Date signed 1/4/47

X

V S 150

7201

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G47201

1220

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkins
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs. Ella C. Bloom

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | M |

6 (b) Name of husband or wife Harry J Bloom
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) July 15 1848

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 98 | 5 | 17 | hr. min. |

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Domestic
11. Industry or business House wife

FATHER
12. Name William H Black
13. Birthplace MARYLAND

MOTHER
14. Maiden Name ROSE Kuhn
15. Birthplace MARYLAND

16 (a) Informant Harry J Bloom
(b) Address Ellicott City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/47 (month) (day) (year)
(c) Cemetery or crematory U.S. National
Location Balto City

18 (a) Funeral director Edw. S. MacGrath
(b) Address Catonsville Md.

JAN 6 1947 (Date rec'd by Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 28 1946, to Jan 2 1947 and that I last saw h[er] alive on Jan 2 1947.

Immediate cause of death — Cardiac decompensation with auricular flutter

Due to Intestinal obstruction

| Duration |
|---|
| |
| |
| |
| over |

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Dec 29, 1946

Major findings of operations: Massive P.O. & inflammatory adhesions

If autopsy: Obstruction

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alfred A Gannon M. D.
Address St Agnes Hosp. Date signed 1/2/47

VS 150

G17202

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 92B

Registered No. G17202

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2039 McCulloh
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2039 Mc Culloh
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hamil & Guerrant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-4-86 1877

8. AGE: Years 69 | Months 4 | Days 30 29 | If less than one day hr. min.

9. Birthplace Danville, Va
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James Hanibal Gurrant
13. Birthplace Danville, Va

MOTHER
14. Maiden Name Sarah Lasley
15. Birthplace Danville, Va

16 (a) Informant Viola M. Coleman
(b) Address 2039 Mc Culloh St

17 (a) Burial (b) Date thereof 1-6-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location City

18 (a) Funeral director Jesse W. Redden
(b) Address 436 W. Biddle St.

19 (a) JAN 6 1947 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 1947, at 3 50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 22 1946 to Jan 3 1947. and that I last saw h alive on Jan 1 1947.

Immediate cause of death Mitral Insufficiency

Due to Arterio-sclerosis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J Edward Fisher M.D.
Address 2462 E. Monument Date signed Jan 3/47

VS 150

Birth Certificate
G17203
D-66898

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓161a

G17203

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address MONUMENT & RUTLAND AVE
(c) Hospital or institution:
SINAI HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town BALTIMORE 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 719 S. MONTFORD AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BABY GRIST MARY CRIST

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| FEMALE | WHITE | SINGLE |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5 - 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | 5 hr. 5 min. |

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name PAUL FRANK GRIST
13. Birthplace BALTIMORE Md

MOTHER
14. Maiden Name LORAETTA WAWRZYNIAK
15. Birthplace BALTIMORE, Md

16 (a) Informant PAUL FRANK GRIST
(b) Address 719 S. MONTFORD AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1-6-47 (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS
Location BALTIMORE, Md

18 (a) Funeral director George A. Weber
(b) Address 705 S Ann st

19 (a) (Date rec'd by registrar) (b) Baltimore, Md

JAN 6 1947 Huntington Ave

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/5 1947, at 7¼ M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5 1947 to 1/5 1947, and that I last saw h[illegible] alive on 1/5 1947.

Immediate cause of death Anoxemia 5 cerebral damage: telectasis due to

| | Duration |
|---|---|
| Due to aspiration | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Stanley H Yffe M. D.
Address 5 Cath Hopk Date signed 1/5/47

X

G47204

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 107

G47204 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 212 Homewood Ave.
(c) Hospital or institution:
91
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 212 Homewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Daniel Muldoon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Martha Muldoon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 80 | Months | Days | If less than one day hr. min. 81

9. Birthplace Ontario Canada (Town, county, and state)

10. Usual Occupation Artist

11. Industry or business

FATHER 12. Name Michael Muldoon
13. Birthplace Ireland

MOTHER 14. Maiden Name Eliza McCusker
15. Birthplace Ont

16 (a) Informant Lynn Tracey
(b) Address Montreal Canada

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/47 (month) (day) (year)
(c) Cemetery or crematory Johnnie
Location Forestville Md

18 (a) Funeral director Tallom & Son Inc
(b) Address 1219 E Oliver St

19 (a) (Date rec'd by registrar) JAN 5 1947 (b) Huntington Williams Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 3 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1946 to Jan 2 1947 and that I last saw h alive on 19

Immediate cause of death Cardiac Asthenia — Duration

Due to

Due to

Other Conditions Bronchitis Pneumonia — 5 days
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature M. L. Lichtenberg M.D.
Address 708 E North Ave Date signed 1/3/47

X

G47205

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 99

G47205 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3736 Hickory Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Hildebrandt
3 (b) If veteran, name war W
3 (c) Social Security Account No. None

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Florence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 28th 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 4 | 6 | hr. min. |

9. Birthplace Balto. Co. Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Samuel Hildebrandt
13. Birthplace Pa

MOTHER 14. Maiden Name Sarah Lockner
15. Birthplace Balto. Co. Md.

16 (a) Informant Rosie Hoffnagle
(b) Address 3736 Hickory Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ St. Mary's - Hampden
Location Balto Md.

18 (a) Funeral director William Bok Inc
(b) Address 127 E. Paul St Baltimore, Md.

19 (a) JAN 6 1947 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4 1947, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1946 to Jan 4 1947; and that I last saw h[illegible] alive on Jan 3 1947.

Immediate cause of death Cardiac Failure — Duration

Due to Uremia — Obstruction of bladder

Due to Kidneys

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Hydronephrosis, Renal Thrombosis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis H. Tankin M. D.
Address Sinai Hospital Date signed 1/7/47

LOUIS H. TANKIN X

VS 150

G47206

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1121

G47206 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland Raynes Apt. 2 Parkland St
(b) Street address ~~1000 W. Lombard St.~~
(c) Hospital or institution: West Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs. Christine W. Kleeby.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Leopold A. Kleeby.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1865

8. AGE: Years 81 | Months 1 | Days 0 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Rev. Karger
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina
15. Birthplace Germany

16 (a) Informant Leopold A. Kleeby
(b) Address 100 W. Lombard St.

17 (a) Burial (b) Date thereof 1/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) (b) Huntington Williams, M.D. Registrar
(Date received by registrar) JAN 8 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4, 1947 at 12:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-29 1947 to 1-4 1947 and that I last saw h[illegible] alive on 1-2-1947

| Immediate cause of death | Duration |
|---|---|
| Peritonitis | |
| Due to Ruptured appendicitis | |
| Due to Acute appendicitis | |
| Other Conditions Hydronephrosis, Hydrometer ureter: Infection Pneumonia Bilateral (Include pregnancy within 3 months of death) | |

Date of operation None
Major findings of operation:
of autopsy: Findings as above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry T. Unger M.D. M. D.
Address West Balto Gen. Date signed 1-4-47

VS 150

G47207

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 128

G47207 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd St & Calvert
(c) Hospital or institution: Union Memorial Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19ds
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County 1
(c) City or town Baltimore 15
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4436 Clydale Ave (If rural give location) b/w Clydesdale
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** James Linardi

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Mrs Grace Linardi
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 3, 1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | 11 | 1 | hr. min. |

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Shoe maker
11. Industry or business Own

FATHER
12. Name John Linardi
13. Birthplace Italy

MOTHER
14. Maiden Name Angela Cardeso
15. Birthplace Italy

16 (a) Informant Mrs Grace Linardi
(b) Address 4436 Clydale Ave, Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) JAN 6 1947 (b) (Signature and title)
Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan 4, 1947; at 10:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 17 1946 to Jan 4 1947, and that I last saw him alive on Jan 4 1947.

Immediate cause of death: Acute hemorrhagic pancreatitis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Blazer M. D.
Address Union Memorial Hosp Date signed

X

G47208

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

Registered No. G47208

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. W

(d) Length of stay in hospital or inst. (yrs., mos., or days) DDay
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 507 Beaumont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** AMELIA C. WISE

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) ~~Single, married~~, widowed, or divorced | 6 (b) Name of husband or wife | 6 (c) If alive, give age |
|---|---|---|---|---|
| F | W | Widowed | Frank E. Wise | years |

7. Birth date of deceased (mo., day, yr.) June 23rd 1864

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | 6 | 11 | hr. min. |

9. Birthplace Cincinnati Ohio
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Christof
13. Birthplace Un Known

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Arthur Bell
(b) Address 507 Beaumont Ave

17 (a) Burial (b) Date thereof 1/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto.
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (b)
(Date rec'd by local registrar) Registrar

JAN 6 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/4 1947, at 10 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18 1946 to 1/4 1947, and that I last saw her alive on 1/4 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardio respiratory failure | |
| Due to Cerebral hemorrhage | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(c) Means of injury
23. Signature [illegible]
Address Univ. Hosp. Date signed 1/7 M. D.

X

G17203 BGH G64958 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 119a G17203 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 21 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County — Baltimore
(c) City or town Baltimore Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. 206 Cord St. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Purcell, Larry Gene

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | S |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 14, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 24 | hr. min. |

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business —

FATHER 12. Name Edwin Purcell
13. Birthplace W. Va.

MOTHER 14. Maiden Name Lucille Marlow
15. Birthplace W. Va.

16 (a) Informant Edwin Purcell
(b) Address 206 Cord ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 / 6 / 47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location

18 (a) Funeral director Sparrow Funeral Home
(b) Address 7494 Belair Rd

19 (a) JAN 6 1947 (Date filed by registrar) (b) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 4, 1947 at 9 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4, 1947 to Jan 4, 1947 and that I last saw h.. alive on Jan 4, 1947.

| Immediate cause of death | Duration |
|---|---|
| Acidosis | |
| Due to Dehydration | |
| Due to Diarrhea | |
| Other Conditions Eczema | |

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: Dehydration, Clavicle Swelling

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Estelle H. Taylor M.D.
Address Chester City Hosp. Date signed 1/5/47

Huntington Williams, M.D.

G47210

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 132

Registered No. G47210

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17d
(e) Length of stay in Baltimore (yrs., mos., or days) 62yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1237 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs Jennie McLafferty

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower.
6 (b) Name of husband or wife: Deceased
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 27 1884
8. AGE: Years 62 | Months 5 | Days 8 | If less than one day — hr. — min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

MOTHER / FATHER
12. Name Julius Bernmaier
13. Birthplace Maryland
14. Maiden Name Josephine Kirchof
15. Birthplace Maryland

16 (a) Informant Mrs Lafferty
(b) Address 1237 Washington Blvd.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location E end of North Ave
18 (a) Funeral director Joshua Bowen & Son
(b) Address 902-03 Holliday St.
19 (a) (Date rec'd by registrar) (b) (Registrar)

vs JAN 6 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-4-47 19 , at 1 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17- 1946 to 1-4- 1947, and that I last saw her alive on 1-3- 1947

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure | 7d |
| Due to Uremia | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D. Kain M.D.
Address Church Home & Hosp. Date signed 1-7-47

G47211 — BALTIMORE CITY HEALTH DEPARTMENT — G47211

# CERTIFICATE OF DEATH 309

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Mercy Hosp. 4
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 521 E. Balto St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) Full name (Dolly) Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Harry Stewart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 29 (1924)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 18 (22) | 11 | 25 | hr. min. |

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Dancer

11. Industry or business

FATHER — 12. Name Henry Boarman

13. Birthplace New York

MOTHER — 14. Maiden Name Annie Anton

15. Birthplace Maryland

16 (a) Informant Hosp. Record

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/47 (month) (day) (year)

(c) Cemetery or crematory Natural

Location Baltimore Md

18 (a) Funeral director Thos. J. Doone

(b) Address 1210 Eutaw St

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 6 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 1947, at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29 1946 to Jan 3 1947 and that I last saw h[illegible] alive on Jan 3 1947

Immediate cause of death: (a) respiratory failure — Duration: 5 days

Due to: rheumatic myocarditis

Due to:

Other Conditions: Lues?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy: acute myocarditis

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James J. Gulack M. D.

Address Mercy Hosp Date signed 1-3-47

X

G17212

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 193a

G17212 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1019 W. Lexington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1019 W Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6. (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife John B. Jones
6 (c) If alive, age ago years

7. Birth date of deceased (mo., day, yr.) 6/4/1891

8. AGE: Years 56 | Months 6 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Daniel Rich
13. Birthplace Va

MOTHER 14. Maiden Name Mary Jones
15. Birthplace Md

16 (a) Informant Dorothy Allen
(b) Address 845 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Brandt Ave

19 (a) (b)
(Signature of registrar) Hampton Williams, Registrar
JAN 6 1947

VS 150

1/2/47

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-2 1947 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 1946 to 1-2 1946 and that I last saw h alive on 1-2 1946

Immediate cause of death: Uremic Nephritis — Duration 1 Mo

Due to — Duration 22 Da

Due to — Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B Hall M.D.
Address 1225 Linden Ave Date signed 1/6/47

47213

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

50

G47213 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 6 Monument St.
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State ~~Md.~~ (b) County
(c) City or town ~~Baltimore~~ East Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 67 Monn St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hannah Lebowitz (Hannah Lebowitz)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife Louis Lebowitz
6 (c) If alive, give age yrs.

7. Birth date of deceased (mo., day, yr.) Sept. 13 1906
8. AGE: Years 40 | Months 3 | Days 22 | If less than one day hr. min.
9. Birthplace Bristol Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Meyer Gutmann
13. Birthplace Germany

MOTHER
14. Maiden Name Esther Friedman
15. Birthplace Cincinnati, Ohio

16 (a) Informant Mrs. Bernard Kohn
(b) Address Dumbarton, Pikesville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/47 (month) (day) (year)
(c) Cemetery or crematory Har Sinai
Location Balto. Md.

18 (a) Funeral director David Sondheimer & Son
(b) Address 1902 Eutaw place

19 (a) (Signature of registrar) (b) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-4 1947 at 3 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-5 1946 to 1-4 1947 and that I last saw her alive on 1-4 1947

Immediate cause of death Metastatic Carcinoma
Due to Carcinoma of Breast
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan B. Hyman M. D.
Address Sinai Hospital Date signed 1-4-47

G47214

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

G47214 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5 N. Fremont Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 N. Fremont Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ernst A. Freter

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-5093

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of ~~husband~~ or wife Louise Danglist

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28th 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 4 | 5 | hr. min. |

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Tallyman

11. Industry or business Steamships

**FATHER**
12. Name Karl Freter
13. Birthplace Germany

**MOTHER**
14. Maiden Name Sophie Kastoff
15. Birthplace Germany

16 (a) Informant Ernst M. Freter
(b) Address 1303 Cambria St.

17 (a) Burial (b) Date thereof 1/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Trinity
Location Balto.

18 (a) Funeral director E. J. Fleming & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) (b)
Date rec'd by Local Registrar JAN 6 1947 Registrar Washington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Jan. 3rd 1947, at M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1946, to Jan 3 1947, and that I last saw h[illegible] alive on Jan 2 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardio vascular renal disease | 2 yrs. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature A. H. Carrollus M. D.
Address 4709 Hendon Ave. Date signed 1/7/47

X

G47215

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46E

G47215 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1709 Woodyear St
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 Woodyear St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Wormley

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Charles Wormley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30 1891

8. AGE: Years 55 | Months 3 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

12. Name William Banks
13. Birthplace Va
14. Maiden Name Priscilla —
15. Birthplace Va

16 (a) Informant Robert Scott
(b) Address 1709 Woodyear St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-6-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George H. Helson
(b) Address 1303 Pennsylvania Ave

19 (a) (b)

Received by registrar JAN 6 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 3 1947, at 9 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma, of the Colon.

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Helfrich M.D.
Medical Examiner.
Date signed 1 Jan 47

USPHS

X

47216

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 167

Registered No. 47216

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1419 E. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Willie Evans
(b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
(b) Name of husband or wife: Helen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/24/1918

8. AGE: Years 28 | Months - | Days 9 | If less than one day hr. min.

9. Birthplace Washington N.C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business
12. Name Ed. Evans
13. Birthplace Washington, N.C.
14. Maiden Name Florence Evans
15. Birthplace Washington, N.C.

16. (a) Informant Helen Evans
(b) Address 1419 E. Fayette St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 7, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.
(a) Funeral director Mrs. Lew. H. Hall
(b) Address 1631 Druid Hill Ave.

JAN 6 1947 (c) Harrington Williams M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 2, 1947 at 5 35 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of neck involving the carotid artery and jugular vein

Due to

Other Conditions Multiple stab wounds

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-2-47 at 5:15 P. M.
(b) Where did injury occur? Fairmount & Spring Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Sharp instrument

23. Signature Howard F. Wallis M.D.
Medical Examiner.
Date signed 1-3-47

VS 151

G47217

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G47217

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5701 Stuart Ave
(c) Hospital or institution: No
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5701 Stuart Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Leon Hutchinson Talbott
3 (b) If veteran, name war No
3 (c) Social Security Account No. 217-01-8880
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. DIVORCED
6 (b) Name of husband or wife Camilla Talbott
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) 10/14/87
8. AGE: Years 59 Months 2 Days 24 If less than one day ____ hr. ____ min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Newspaper

FATHER
12. Name Leon A. Talbott
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mollie Miller
15. Birthplace Pittsburgh, Pa.

16 (a) Informant Robert T. Brock
(b) Address 5701 Stuart Ave, City.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-9-47 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore
18 (a) Funeral director Stewart Mortuary
(b) Address 1040 Park Ave.
19 (a) ____ (Date received by registrar) (b) ____ Registrar
JAN 6 1947 Huntington Williamsport, Md

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-4 1947, at 5 M
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1946, to 1-4 1947, and that I last saw h. alive on 1/3 1946
Immediate cause of death Coronary Thrombosis — Duration 1 yr.
Due to arteriosclerotic heart disease — 7
Due to ____
Other Conditions ____
(Include pregnancy within 3 months of death)
Date of operation ____
Major findings of operation: ____
of autopsy: ____

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury ____
23. Signature Paul E. Carlson M. D.
Address 2717 South Rd Date signed 1-4-47.

H 0 E 5/14 G47218

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 B

Registered No. G47218

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 17
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Tuscany Apts
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Berington E. Weller (OVINGTON EUGENE WELLER)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Elizabeth B. Weller

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2-23-62

8. AGE: Years 84 | Months 10 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace Md.
(Town, county and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Wm. F. Weller
13. Birthplace

MOTHER
14. Maiden Name Wilmina Berryman
15. Birthplace

16 (a) Informant Ricardo
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 1-8-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory U.S. Arlington National
Location Arlington Va.

18 (a) Funeral director Sherwood Memorial
(b) Address 1018 Madison Ave.

19 (a) JAN 6 1947 Registrar Huntington Williams, M.D.
(Date Accepted by Registrar)

**MEDICAL CERTIFICATION**

28. DATE OF DEATH Jan 5, 1947 at 6 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 30 1946 to Jan 5 1947 and that I last saw h.i.m alive on Jan 5 1947

Immediate cause of death: Carcinoma of stomach — Duration

Due to.....

Due to.....

Other Conditions Gen. arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature A. M. Knight, Jr. M. D.

Address..... Date signed.....

VS 150

G47219 Purdy

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

131a

Registered No. G47219

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1114 Marshall St
(c) Hospital or institution: 23

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) About 55 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town 1114 Marshall St
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore 30, Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James G. Purdy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife (Nee Cole) Edith M. Purdy
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) May 2, 1875

8. AGE: Years 71 | Months 8 | Days 1 | If less than one day hr. min.

9. Birthplace Arnold, Anne Arundel Co, Md.
(Town, county, and state)

10. Usual Occupation Truck Helper

11. Industry or business Chesapeake & Potomac Tel Co

FATHER 12. Name Samuel Purdy
13. Birthplace Md

MOTHER 14. Maiden Name Anna R. Cook
15. Birthplace Md

16 (a) Informant Mrs. Edith M. Purdy (Wife)
(b) Address 1114 Marshall St, Balto 30 Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 7 1947 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem
Location A. A. Co., Md.

18 (a) Funeral director A. Atwood Gown
(b) Address 1400 E. Biddle St, Balto 30 Md

19 (a) (Date rec'd by registrar) (b) (Registrar) Wilmer Mohr Lansdon Jr. M.D.

JAN 6 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 3 1947, at 6:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1946 to Jan 2 1947
and that I last saw h[illegible] alive on Jan 2 1947.

Immediate cause of death
Myocarditis — Duration 3 days

Due to Septicemia — Duration unknown

Due to Hypertension — Duration unknown

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wilmer Mohr Lansdon Jr. M.D. Date signed 1/6/47

G472,20

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G472,20

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1338 E. Fort Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1338 E. Fort Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Phillip E. Rice

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-7081

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose Rice (Nee Meyers) 6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1887

8. AGE: Years 59 | Months 10 | Days 3-29 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Carpenter Leader/Kay

11. Industry or business Bethlehem Steel Co. Yd.

FATHER
12. Name George W. Rice
13. Birthplace Md.

MOTHER
14. Maiden Name Betty L. Cornell
15. Birthplace New York State

16 (a) Informant Mrs. Rose Rice (Wife)
(b) Address 1338 E. Fort Ave. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 6 1947 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Anne Arundel Co., Md.

18 (a) Funeral director A. Howard Evans
(b) Address 1000 E. Baltimore St., Balto. 3, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3, 1947, at 6:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Jan 3 1947, and that I last saw him alive on Jan 3 1947.

| | Duration |
|---|---|
| Immediate cause of death: Coronary Occlusion | 30 minutes |
| Due to: Coronary Thrombosis | 6 months |
| Due to: Coronary Sclerosis | 15 yrs |
| Other Conditions: | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Walter Lohr
Address 1020 E. Fort Ave Date signed 1/3/47

VS 150 JAN 6 1947

Hunter Williams M.D.

G17221

BALTIMORE CITY HEALTH DEPARTMENT X

# CERTIFICATE OF DEATH 46a

Registered No. G17221

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount X
(c) Hospital or institution:
Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 637 Orington Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] George Leroy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife Elizabeth Leroy
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) June 1, 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 7 | 2 | ....hr. ....min. |

9. Birthplace Germany
(Town, county, and State)
10. Usual Occupation Sheet Metal worker
11. Industry or business

FATHER
12. Name John Frederick Leroy
13. Birthplace Germany

MOTHER
14. Maiden Name Pauls Erdmuth
15. Birthplace Germany

16 (a) Informant Daughter Mrs. B. Mattee
(b) Address 641 Orington Rd.

17 (a) Burial (b) Date thereof Jan 6 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave & Longwood St
18 (a) Funeral director Harry A Wetzel
(b) Address 4101 Edmondson Ave.
19 (a) (Date received by registrar) JAN 6 1947 Registrar William M. Church Home & Hospital Date signed Jan 47

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3 1947, at 5:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 27 1946 to Jan 3 1947, and that I last saw him alive on Jan 3 1947

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure & Bronchial pneumonia | 2 days |
| Due to General debility | 1 Da |
| Due to Carcinoma of Esophagus | Months |
| Other Conditions | 7 |

(Include pregnancy within 3 months of death)
Date of operation Dec 27 1946
Major findings of operation: Metastatic nodules on bowel
of autopsy: Ca. of Esophagus & metastasis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A Rowe M. D.
Address Church Home & Hospital Date signed Jan 47

X

then G47222 !

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1318 Registered No. G47222

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 624 E. Eutaw St
(c) Hospital or institution:
17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 624 E. Eutaw ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Sophie Fisher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Wm August

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1859

8. AGE: Years 87 Months 5 Days 25 If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Andre
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Miss Margaret Fisher
(b) Address 624 E. Eutaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 7 '47 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave + Longwood St

18 (a) Funeral director Harry N Wyche
(b) Address 4101 Edmondson Ave

19 (a) (Date received by registrar) JAN 6 1947 (b) Filing [illegible] Williams M.D. 1317 Hamilton Ave Date signed Jan 4/47

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1946, to Jan 4 1947, and that I last saw h[illegible] alive on Jan 3 1947.

Immediate cause of death: Chronic Nephritis — Duration: several years

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Patterson M. D.

VS 150

X

G17223

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. G17223

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 663 Fairmount Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 663 Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Maggie Williams

3 (b) If veteran, name war | Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Col. | Widow |

6 (b) Name of husband or wife Squaw Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24/1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | - | 10 | hr. min. |

9. Birthplace Rose Hill N.C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Bob. Graham
13. Birthplace Rose Hill N.C.

MOTHER
14. Maiden Name Anna.
15 Birthplace Rose Hill N.C.

16 (a) Informant William Brown
(b) Address 663 Fairmount Ave

17 (a) Shipped (b) Date thereof Jan. 6, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Wesson N.C.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) [illegible] by registrar JAN 6 1947 Registrar

V S 190

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/3 1947; at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1945 to 1/3 1947 and that I last saw h[illegible] alive on 1/9 1947

Immediate cause of death (a) Chronic Myocarditis
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

| Duration |
|---|
| |
| |
| |
| |
| |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David J. Weinman M. D.
Address 1212 W Lee Date signed 1/6/47

G47224 G47224

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓50

Registered No.....

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 709 N.Carrollton Ave
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County.....
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 709 N.Carrollton Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

**3 (a) FULL NAME** SARAH A. JACKSON

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | C | Widowed |

6 (b) Name of husband or wife George A. Jackson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/3/1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 10 | 0 | ..... hr. ..... min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Andrew Jackson (Son)
(b) Address 709 N.Carrollton Ave

17 (a) Burial (b) Date thereof 1/6/1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk.
Location Baltimore County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-512 N.Carrollton Ave

JAN 6 1947 (b).....
(Date rec'd by registrar)

VS 150
JAN 6 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/3/47 19..., at 3:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/12 1946 to 1/3/1947 and that I last saw he alive on 1/3/1947.

Immediate cause of death Carcinomatosis — Duration

Due to Carcinoma Breast

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operations.....

of autopsy.....

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature W. F. Howell M. D.
Address 601 N Carrollton Ave Date signed 1/5/47

D. of H. Rutland. To be granted by Chief Med. Exam., Md. Medical Exam Law

BCH# G60550

G47225

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 1579

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1604 E. Hoffman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Helen Rogan.

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Black. | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 2 1/2 | | hr. min. |

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Curtis Rogan
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 6/47 (Month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location A. A. County Md

18 (a) Funeral director Mrs Robt A. Elliott Undtk
(b) Address 1129 N. Carolina St.

19 (a) 1947 (Date received by reg.) (b) Signature of Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 3 1947 at 9.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1947, to — 19..., and that I last saw h... alive on — 19...

Immediate cause of death: Dead on arrival — Duration

Due to: Cause undetermined

Due to:

Other Conditions: Colostomy

(Include pregnancy within 3 months of death)

Date of operation Nov. 1946

Major findings of operation: Imperforate anus, rectovesical fistula, incomplete atresia

of autopsy: same plus an closed ...

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lee Neil Bass M. D.
Address Johns Hopkins Hosp. Date signed 1-4-47

George L. Merrill MD.

VS 150

G17226

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. G17226

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Lyndhurst Ave. & Dukeland St.
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 724 Lyndhurst St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Henry Conrad Fritz

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | 212-05-0776 |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Ada F. Fritz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1899

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 47 | 3 | 13 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Exchange Repairman
11. Industry or business C. & P. Telephone Co.

FATHER
12. Name Henry C. Fritz
13. Birthplace Germany

MOTHER
14. Maiden Name Bertha Seeger
15. Birthplace Germany

16 (a) Informant Mrs. Ada F. Fritz
(b) Address 724 Lyndhurst St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/47 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

(a) 1947 (Date rec'd by registrar) [illegible] Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 4, 1947 at 10:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 18, 1946 to Jan. 4, 1947 and that I last saw him alive on Jan. 4, 1947

| Immediate cause of death | Duration |
|---|---|
| Renal failure (Uremia) | |
| Due to Chronic nephritis | |
| Due to | |
| Other Conditions Hypertensive cardiovascular disease (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leon Toby M.D.
Address West Balto. Gen. Hosp. Date signed 1/4/47

VS 150

G47227

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V94a

G47227

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3903 Norfolk Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 23yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3903 Norfolk Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Samuel Stein

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | | | hr. min. |

9. Birthplace Russia (Town or county and state)
10. Usual Occupation Sheet Metal Contractor
11. Industry or business

FATHER
12. Name Mayer Lait
13. Birthplace Russia

MOTHER
14. Maiden Name Debgria
15. Birthplace Russia

16 (a) Informant Ida Stein
(b) Address 3903 Norfolk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-6-47 (day) (year)
(c) Cemetery or crematory Beth Tfiloh
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 1469 E Baltimore St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Md.

6/5 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-6-1947; at 1:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/6 19 to 1/6 1947
and that I last saw h alive on 1/6 1947
Immediate cause of death

| | Duration |
|---|---|
| Acute Coronary infarction | |
| Due to | |
| Due to | |
| Other Conditions — | |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —, at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —
23. Signature A. L. Stornstein, M.D.
Address 733 Argyle St Date signed 1/6/47

X

G47228

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 153

G47228 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution Sinai Hospt 6W

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2514 E. Balto St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Sarah Goldmann

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | M |

6 (b) Name of husband or wife Aaron
6 (c) If alive, give age years

7. Birth-date of deceased (mo., day, yr.) 1916

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 31 | | | 1945 min. |

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Victor Caplan
13. Birthplace Lith.

MOTHER
14. Maiden Name Mary
15. Birthplace Lith

16 (a) Informant Hospt Records
(b) Address

17 (a) Burial (b) Date thereof 1-6-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Reservoir Hill Rd & Fremeton Ave
Location
18 (a) Funeral director Jacob Lewis Inc
(b) Address 1439 E. Balto St. Huntington Williams, Md

6 (a) 1947 (b) Registrar
(Date received by registrar)

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 1-5-47 19 , at 11 55 A.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from 9-24-1946 to 1-5-1947, and that I last saw h[illegible] alive on 1-5-1947

| Immediate cause of death | Duration |
|---|---|
| Circulatory failure | |
| Due to Nephrotic Syndrome | |
| Due to Lupus erythematosus | |
| Other Conditions arteriosclerosis, pericarditis, uraemia | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bertha Reder M. D.
Address Sinai Hospital Date signed 1-5-47

VS 150

G17229

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

G17229 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 41 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 years.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County B
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2022 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence W Smith (Clarence W. Smith)

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-10-9019

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Flora Pearl Smith

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1893 Oct 31, [illegible]

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 yrs | 2 | 5 | hr. min. |

9. Birthplace Delaware
10. Usual Occupation Electric Pump Operator.
11. Industry or business Baltimore City (Town, county, and state)

MOTHER | FATHER

12. Name William Smith
13. Birthplace Snow Hill Maryland.
14. Maiden Name Martha LeCates Martha Le Cates
15. Birthplace Delaware Delaware

16 (a) Informant Mrs. Flora Pearl Smith
(b) Address 2022 Harlem Ave.

17 (a) Burial (b) Date thereof Jan. 9, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parsons Cemetery
Location Salisbury, Md.

18 (a) Funeral director Hilkie Lamotte
(b) Address 4510 Liberty Heights Ave.

Jan 6 1947 (b) [illegible]
(Date rec'd by registrar) Huntington Williams, Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5/47 19 , at 3-10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/26/46 19 , to 1/5/47 19 , and that I last saw him alive on 1/5/47 19 .

Immediate cause of death Uremic poisoning — Duration

Due to Chronic nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: Uremic nephritis Cerebral hemorrhage

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph H. Pritchard M. D.
Address Church Home & Hosp. Date signed 1/5/47

VS 150

G17230

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

G17230 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3917 Liberty Hgts Ave
(c) Hospital or institution: Dor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3917 Liberty Hgts Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John B. Mac Allister

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-5922

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Katherine Mac Allister

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) May 8, 1893

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | 7 | 27 | hr. min. |

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Stencil Cutter

11. Industry or business Balto Porcelain Steel Corp

12. Name Thomas Mac Allister

13. Birthplace Balto. Md.

14. Maiden Name Annie Hoover

15. Birthplace Georgia

16 (a) Informant Katherine Mac. Allister

(b) Address 3917 Liberty Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 7, 1947 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location 3801 Frederick Road

18 (a) Funeral director Mrs. Mrs. John W. Tenfel's Son

(b) Address 5311 Edmondson Ave

19 (a) JAN 6 1947 (Date received by registrar) Williams, M.D.

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/4 1947, at 1:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature C. J. Lubinski M.D.
Medical Examiner.

Date signed 1/7/47

Parke Application
G47231
G-66897

G47231

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1161c

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6'
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15 N. Glover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Rappelt

3 (b) If veteran, name war — 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | W. | — |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4/47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 2/1 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business —

FATHER 12. Name Frank Rappelt
13. Birthplace Baltimore

MOTHER 14. Maiden Name Antonetta Mazzei
15. Birthplace Baltimore

16 (a) Informant Frank Rappelt
(b) Address 15 N. Glover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore

18 (a) Funeral director Fred W. Ozazewski
(b) Address 1730 Eastern Ave

19 (a) [illegible] (Date rec'd by [illegible]) (b) [illegible] Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/4 1947, to 1/5 1947, and that I last saw him alive on 1/5 1947

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Edema | |
| Due to Erythroblastosis Fetalis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy Erythroblastosis Fetalis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature England O. Gardella M. D.
Address Sinai Hospital Date signed 1/6/47

VS 150

G47232

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93E

G47232 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1917 Sapp St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 Sapp St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Tyree

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 16 1885

8. AGE: Years 61 | Months 3 | Days 16 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace Va

16 (a) Informant Wilbert Tyree
(b) Address 1917 Sapp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-6-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) (b) Registrar

Date received by registrar JAN 6 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1947 at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1946 to Jan 2, 1947. and that I last saw h[im] alive on Jan 15 1946

Immediate cause of death: Cerebral Coagulation Heart failure — Duration: 1 yr

Due to

Due to

Other Conditions Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice Adams M. D.
Address 138 N. Grey St Date signed 1-4-47

X

G47233

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

Registered No. G47233

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1609 Latrobe St.
(c) Hospital or institution: 17

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 Latrobe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME Matilda Turner

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

(b) Name of husband or wife

6 (c) If alive, give age years

Birth date of deceased (mo., day, yr.) July 4 1868

AGE: Years 47 | Months 5 | Days 29 | If less than one day: hr. min. 18

Birthplace Virginia (Town, county, and state)

7. Usual Occupation Housewife

8. Industry or business

12. Name Edmond Davis

13. Birthplace Va.

14. Maiden Name Nettie Taley

15. Birthplace Va.

(a) Informant Howard Turner

(b) Address 1714 Brentwood Ave

16. (a) Shipped (Burial, cremation, or removal) (b) Date thereof 1 6 47 (month) (day) (year)

(c) Cemetery or crematory Frey Union Gen

Location Mecklenburg Co. Va.

17. (a) Funeral director Rayner & Sanders

(b) Address 1412 E. Preston St

(a) 1947 (Date rec'd by registrar) (b) [illegible] M.D.

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 1947, at 1:05 P M

21. I certify that I took charge of the remains described above, held an Inquest Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Carcinoma of the breast
& metastases

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. [illegible] M.D. Medical Examiner.

Date signed 1-3-47

G17234

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1108

Registered No. G17234

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1704 Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** James R Kelly
3 (b) If veteran, name war: I.
3 (c) Social Security Account No. 218-09-1904

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Col. | Married |

6 (b) Name of husband or wife: Anna Kelly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | 11 | 26 | hr. min. |

9. Birthplace Howard Co. Md.
(town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Alfred Kelly
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Rachel Handy
15. Birthplace Howard Co. Md.

16 (a) Informant Anna Kelly
(b) Address 1704 Edmondson Ave

17 (a) Burial (b) Date thereof Jan. 7 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director Wm. Katzenberger & Williams
(b) Address 325 W. Lexington St.

19 (a) JAN 6 1947
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/3 1947 at 12A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/26 1946 to 1/3 1947 and that I last saw h[illegible] alive on 1-3 1947.

Immediate cause of death: Lobar Pneumonia — Duration: 7
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature B. F. Hatcher
Address 1 W Mt Pl Date signed 1/6/47

V S 150

G47235

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 108

G47235 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1505 W. Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 W. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Susie Harris

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Col. | Widow |

6 (b) Name of husband or wife James Harris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13 1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 6 | 19 | hr. min. |

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Georgiana ?
15. Birthplace Md.

16 (a) Informant Pearl Clark
(b) Address 469 Watts Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 6 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem.
Location

18 (a) Funeral director Mrs Katie B Hollingsworth
(b) Address 922 N Belnord Ave

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 6 1947 Huntington Williams, Mgr

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1947, at 5 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 31 1946 to Jan 2 1947, and that I last saw her alive on Jan 1 1947

| Immediate cause of death | Duration |
|---|---|
| Lobar Pneumonia | 1 week |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Douglas Shepherd M. D.
Address 607 N. Bolton Ave Date signed 1/4/47

X

JL -G47236

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 93D

Registered No. G47236

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1236 N. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ann Elizabeth Smith

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | Widowed |

6 (b) Name of husband or wife John (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | 11 | 2 | hr. min. |

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Julius Yearby
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah Thomas
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 6 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Kate R. Gallagher
(b) Address 922 N. Schroeder St

19 (a) (Date rec'd by registrar) (b)

VS JAN 6 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2 1947, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 23 1946, to Jan. 2 1947, and that I last saw h alive on Jan. 2 1947.

| Immediate cause of death | Duration |
|---|---|
| Circulatory Failure | |
| Due to Congestive Heart Failure | |
| Due to Hypertensive Cardiovascular Disease | |
| Other Conditions Chronic Acute Pyelonephritis, R.P. (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy Same as above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. R. Scharbrough M. D.
Address Balto City Hosp. Date signed 1-3-47

AB-105851 47237

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1/13 47237

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos- 6days
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 916 N. Carrollton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** James Francis Chandler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ruth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13- 1907

8. AGE: Years 39 | Months 1 | Days 21 | If less than one day ____hr. ____min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Richard Chandler
13. Birthplace Va.

MOTHER
14. Maiden Name Anna Upsher
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 8, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 822 N. Broadway

19 (a) [illegible] (Date rec'd by registrar) (b) [illegible] Registrar

V S 130

**MEDICAL CERTIFICATION** AM

20. DATE OF DEATH Jan. 4- 1947, at 6.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-28 1946, to 1-4- 1947, and that I last saw h im alive on 1-4- 1947.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Tuberculosis | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: No

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. E. Robinson Jr. M. D.
Address Balt. City Hosp. Date signed 1/5/47

S07302 G47238

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 177a

G47238 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1026 W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** DeSota Gross.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Black | Married |

6 (b) Name of husband or wife Mark Gross
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-6-08

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 38 | 2 | 28 | hr. min. |

9. Birthplace N.C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name William ?
13. Birthplace N.C.

MOTHER 14. Maiden Name Nancy ?
15. Birthplace Va

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Jan. 8, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 352 W. Lanvale St.
(c) Date rec'd by registrar JAN 6 1947 (b) Lillington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan. 3 1947 at 5.50 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1947 to Jan 3 1947 and that I last saw her alive on Jan 3 1947

| Immediate cause of death | Duration |
|---|---|
| Respiratory paralysis | |
| Due to Botulism | 4 days |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Nothing significant

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature Eo Howard M. D.
Address Johns Hopkins Hosp signed 1/5/47

VS 150

G47239

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

131a

Registered No. G47239

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3701 Elm Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3701 Elm Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Rohr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife William Edward Rohr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3-1875

8. AGE: Years 71 | Months 1 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Philip Geidt
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Kirkheimer
15. Birthplace Germany

16 (a) Informant David Helwig Rohr
(b) Address 3701 Elm Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 7-1947 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road Baltimore, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 4- 1947 at 6 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 18 1945 to Jan 4 1947 and that I last saw her alive on Jan 4 1947

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | 1 day |
| Due to Cardio-Renal Vascular Disease | 6 yrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. N. Nelson M. D.
Address 617 W. 40th Date signed 1/6/47

MAR 8 1947

X

G17240

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G17240 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 543 W. Lafayette Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAM LEVENTON or Sam Livingston

(b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced. Widowed

(b) Name of husband or wife Cornelia Livingston
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Wilmington, N. C.
(Town, county, and state)

10. Usual Occupation Carpenter
11. Industry or business

12. Name James Livingston
13. Birthplace N. C.
14. Maiden Name Jamie ?
15. Birthplace N. C.

16 (a) Informant Rosa Shipsingay
(b) Address 1410 Church St. Wilmington N. C.

17 (a) Burial (b) Date thereof Jan 6, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location

18 (a) Funeral director Clegg & Wilson
(b) Address 1000 Broadway

19 (a) MAR 6 1947 Huntington Williams, M.D.
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28, 1946, at 8.45 PM

21. I certify that I took charge of the remains described above, held an inspec. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 12-30-46

VS 161

G17241

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G17241 1695 22 1316

Registered No. G17241

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 715
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 513 N. Bethel St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** George Ford.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | black | Sep. |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-15-92

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 | 9 | 14 | hr. min. |

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Sandy Ford.
13. Birthplace Va

MOTHER
14. Maiden Name Mandie Hunt
15. Birthplace Va

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 1/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Brant Ave

19 (a) (Date received by registrar) JAN 8 1947 (b) Huntington Williams

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Dec. 29 1946 at 12 15 A.M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 12-12-1946 to 12-29-1946, and that I last saw him alive on 12-29-1946.

| Immediate cause of death | Duration |
|---|---|
| Uremia | 4 Mo's |
| Due to chronic glomerulo nephritis | 6 Mo's |
| Due to | |
| Other Conditions Uremic pericarditis | 4 days |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature Eugene Meyer III M. D.
Address Johns Hopkins Hosp. Date signed Dec 29 46

VS 150

G47242

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G47242 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2816 W. North Ave.
(c) Hospital or institution: 15 1/2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2816 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** CAROLINE M. WOOTERS (Caroline M. Letz)

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife William W. Wooters
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 2 | 11 | hr. min. |

9. Birthplace Philadelphia, Pa.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Albright
13. Birthplace Pa.

MOTHER
14. Maiden Name Roseanna Sailer
15. Birthplace Pa.

16 (a) Informant Mrs. Agnes Jenkins
(b) Address 2816 W. North Ave.

17 (a) Removal (b) Date thereof 1/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory North Cedar Hill Cem.
Location Phila., Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) JAN 6 1947 (b) Huntington Wilkinson, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 4, 1947, at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1935 to Jan 4 1947, and that I last saw her alive on Jan 4 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | 48 hours |
| Due to arteriosclerosis | 1 year |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwith Mortimer Jr. Md M. D.
Address 2726 St Paul St Date signed 1/6/47

G47243

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13 1a

Registered No. G47243

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1824 E. 32nd St.
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1824 E. 32nd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** FLORENCE WORTHINGTON WHALEY

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | no |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widow |

6 (b) Name of husband or wife John H. Whaley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, ~~1872~~ 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| (74) 73 | 0 | 24 | hr. min. |

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business None

FATHER
12. Name ~~Benj. Thomas~~ Worthington
13. Birthplace Md.

MOTHER
14. Maiden Name Mitilda Harmon
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Howard N. Whaley, Daughter in- Law
(b) Address 1824 E. 32nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 7, 1947 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date received by registrar) Registrar

JAN 6 1947

VS 150

Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan. 4, 1947, at 9P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from January 4 1946, to Jan 4 1947 and that I last saw h.er alive on Jan 4 1947

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia | 4d |
| Nuremia | 5d |
| Due to Hypertension | 4yr |
| Arteriosclerosis | 14yr |
| Due to Chr Interstitial Nephritis | 15yr |
| | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature Ida Stevens M. D.
Address 2818 Harford Rd Date signed 1-6-47

G47244

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 97

G47244 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 413 N Pine St
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 413 N Pine St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eliza Coates

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 13, 1875

8. AGE: Years 71 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Henry Spicer
13. Birthplace Md

MOTHER 14. Maiden Name Anna Mills
15. Birthplace Md

16 (a) Informant Mamie West
(b) Address 413 N. Pine St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 7/47 (month) (day) (year)
(c) Cemetery or crematory St Peters Cemetery
Location

18 (a) Funeral director Mr. Robert A. Elliott Sons
(b) Address 1129 N. Carolina St

19 JAN 6 1947 (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 2 1947, at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to Jan 1947, and that I last saw her alive on Dec 26 1946

Immediate cause of death: Auricular fibrillation — Duration

Due to Arteriosclerosis - Hypertension

Due to Heart Failure Kidney Complications

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bernard T. French M. D.
Address 2316 Arunah Ave Date signed 1-4-47

VS 3

225 B.C #-26712

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

159

G47245 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 306 Rock
(c) Hospital or institution: 18

(d) Length of stay in hospital or inst. (yrs., mos., or days) 59 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 59 min

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 306 Rock St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1-6-47

8. AGE: Years | Months | Days | If less than one day: hr. 30 (59) min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Wm Casper White
13. Birthplace Balto, Md

MOTHER
14. Maiden Name Sallie Hunter
15. Birthplace Lexville, South Carolina

16 (a) Informant Sallie White
(b) Address 306 Rock St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location [redacted] JAN 6 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 6 1947 Huntington-Williams, Inc
(Date rec'd by registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 6 1947, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6 1947 to 1-6-1947 and that I last saw h alive on 1-6-1947.

Immediate cause of death Atelectasis — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. S. Campes M. D.
Address 630 N. Carey St Date signed 1-6-47

G17246

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 307

G17246 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 Mc Henry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(a) FULL NAME William E. LONG

(b) If veteran, name war None

3 (c) Social Security Account No. 215-14-7364

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

(b) Name of husband or wife

6 (c) If alive, give age years

Birth date of deceased (mo., day, yr.) [illegible] 1904

| AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 43 | | | hr. min. |

Birthplace Of Moses & Md
(Town, county, and state)

7. Usual Occupation Sheet Metal Worker
8. Industry or business

12. Name Joseph A. Long
13. Birthplace Md
14. Maiden Name Moses A. Bailey
15. Birthplace Md

(a) Informant Thomas C. Long
(b) Address 1508 Cheverley Ave Cheverley Md

(a) Removal (Burial, cremation, or removal) (b) Date thereof Jan 7-1947 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill
Location Washington D.C.

(a) Funeral director Taft & B.M. Walter
(b) Address Pratt & Stricker Sts

N 6 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6, 1947 at 11 30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Left subdural hemorrhage

Edema of lungs

Due to Syphilitic aortitis

Alcoholism

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 1/6/47

VS 151

G17217

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

170c

G17217

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: (University) Hospital (Women's)
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 62
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Clyde HORACE May

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | SINGLE |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 - 26 - 1915

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 31 (32) 31 | - | 10 | hr. min. |

9. Birthplace Franklin Co., (Town, county, and state)

10. Usual Occupation

11. Industry or business

INFORMANT

12. Name Leonard May

13. Birthplace Franklin Co.,

14. Maiden Name Pattie Lee Moody

15. Birthplace Franklin Co.

16 (a) Informant Carilee May

(b) Address Aberdeen Md.

17 (a) Removal (b) Date thereof 1-6-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory (Rose Bank) Bynum N. C.
Location North Carolina

18 (a) Funeral director William Cook Jr.

(b) Address 1217 St. Paul St.

19 (a) (b) Huntington Williams, M.D.
Date rec'd by local registrar

VS 151

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Jan. 5, 1947 at 3.10 P M

**21.** I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Broken neck (Fractured second and seventh cervical vertebrae)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 1-5-47 at 2.40 P. M.

(b) Where did injury occur? South York Rd.-400 ft Ensor Rd.

(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No

(d) Means of injury Pediastrian struck by auto

23. Signature Howard J. Mahler M.D.
Medical Examiner.

Date signed 1-6-47

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47248 / 121a

Registered No. G47248

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 746 W. North Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Mo.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Allegany
(c) City or town Lonaconing
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Linda Grindle

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles N.
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.): April 21, 1875

8. AGE: Years 71 | Months 8 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace: Lonaconing, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: William Green
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Katherine ?
15. Birthplace: Unknown

16 (a) Informant: Mr. Charles O. Grindle
(b) Address: 746 W. North Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/6/47 (month) (day) (year)
(c) Cemetery or crematory: Laurel Hill Lonoconing
Location: Lonoconing, Md.

18 (a) Funeral director: William J. Tickner & Sons
(b) Address: North & Pennsylvania Aves

19 (a) Date rec'd by registrar: Jan 7 1947 (Signature of registrar)

VS 15

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Jan. 6, 1947, at 3:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from January 2, 1947 to January 6, 1947 and that I last saw h.e.r. alive on January 6, 1947.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Edema | |
| Due to Cardiac Decompensation | |
| Due to Arteriosclerotic Cardio-Vascular Renal Disease | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State) Md.
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sigmund Goldberg M.D.
Address 622 W. North Ave Date signed 1-6-47.

X

7219 G17749

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 514 Bethel St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 514 Bethel St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Walkowiak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years 88 | Months | Days | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Kaczor
13. Birthplace Poland

MOTHER 14. Maiden Name Szymont
15. Birthplace Poland

16 (a) Informant Josephine Adamski
(b) Address 514 S. Bethel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 7-47 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus
Location Balto. City

18 (a) Funeral director Wm. S. F. Dalkowski
(b) Address 2007 Eastern Ave.

JAN 7 1947 (Date rec'd by registrar) Hugh J. Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 3 1947 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1946 to Jan 3 1947 and that I last saw h alive on Jan 3 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Apoplexy | 3 Days |
| Due to Uremia & Cerebral Hypertension & Cardio-Vascular Renal Disease | 2 yrs |
| Due to Bronchial Pneumonia | 1 wk |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Chandler M. D.
Address 1701 E. Fayette St Date signed 1/4/47

VS 150

X

Dead Certificate
7250
G-66913

BALTIMORE CITY HEALTH DEPARTMENT X G47250
# CERTIFICATE OF DEATH 159
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland St.
(c) Hospital or institution:
West Balt. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Harford
(c) City or town Joppa
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy Fox

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29. 46

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name ~~Otto~~ Robert Fox
13. Birthplace Owego, New York

MOTHER
14. Maiden Name Alice Stachnick
15. Birthplace Baltimore, Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location [illegible] JAN 6 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 7 1947 (Date rec'd by registrar) (b) [signature] for Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 12-31 1946 at 11:20 AM

**21.** I certify that death occurred on the date above stated; that I attended deceased from 12-29 1946, to 12-31 1946. and that I last saw h[illegible] alive on 12-31 1946.

| Immediate cause of death | Duration |
|---|---|
| Atelectasis | |
| Due to Prematurity | |
| Due to | |
| Other Conditions Mother-Premature Separation of Placenta | |

(Include pregnancy within 3 months of death)
Date of operation Cesarean Section
Major findings of operation: Fibroids
of autopsy: Atelectasis?

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. D. Trapton M. D.
Address W. Balto Gen Hosp Date signed 1-2-47

VS 150

7251

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G17251

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1405 N. Dallas St.
(c) Hospital or institution: Q

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1405 N. Dallas St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Colored | Married |

6 (b) Name of husband or wife Annie Moore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/1/1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | 6 | 3 | hr. min. |

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation LABORER
11. Industry or business —

FATHER
12. Name OSCAR Moore
13. Birthplace Virginia

MOTHER
14. Maiden Name ABott?
15. Birthplace Virginia

16 (a) Informant Annie Moore
(b) Address 1405 N. DALLAS St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 8 47 (month) (day) (year)
(c) Cemetery or crematory Mt CALVARY
Location AA County

18 (a) Funeral director RAYNER SANDERS
(b) Address 1412 E PRESTON St.

19 JAN 7 1947 (Date rec'd by registrar) [illegible] M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 4 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1945 to Jan 4 1947, and that I last saw h[illegible] alive on Jan 3 1947

Immediate cause of death: Cerebral Hemorrhage — Duration 2 days
Due to Hypertension and Cerebral Vascular Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] K. Adams
Address 1222 N. Caroline Date signed 1-7-47

VS 150

G17252

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH √164B

Registered No. G17252

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 705 Eloat Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1248 S. Edwood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (MARGOZATA) Margaret Bogucki

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-07-4807

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 12

8. AGE: Years 25 | Months 6 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Nat'l. Can Co.

11. Industry or business

12. Name John Bogucki

13. Birthplace Poland

14. Maiden Name unknown

15. Birthplace Poland

16 (a) Informant Mrs. Eva Bogucki

(b) Address 1248 S. Edwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 9/47 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus Cem. Location Dundalk Ave

18 (a) Funeral director Stefkum & Fialkowski

(b) Address 1000 S. Kenwood Ave

19 (a) (b) Huntington Williams

DEC 27 1946

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 5, 1947 at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-5-47 at P.M.
(b) Where did injury occur? Harbor: Fort Kenwood Pier
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Found Floating in Harbor

23. Signature Howard J. Wendel M.D.
Medical Examiner.
Date signed 1-6-47

Birth Certificate

G. 66818 G-17253

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G17253 Registered No. 1579

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address FAYETTE + CALHOUN ST
(c) Hospital or institution:
FRANKLIN SQUARE HOSP
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da
(e) Length of stay in Baltimore (yrs., mos., or days) 4 da

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MARYLAND (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2813 Brighton St. Franklin Sq. Hosp.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BABY BOY RESH Resh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex MALE

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 2 1947

8. AGE: Years | Months | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Chas K. RESH

13. Birthplace Baltimore Md.

14. Maiden Name INEZ - BANOTAI

15. Birthplace Baltimore Md.

16 (a) Informant Charles K. Resh (Father)
(b) Address 2813 Brighton St.

17 (a) Burial (b) Date thereof Jan. 7 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~xxxxxxx~~ Holy Redeemer
Location Belair Rd. Baltimore, Md.

18 (a) Funeral director Grant Della Hoe

(b) Address 52 N. Morley St.

19 (a) (Date rec'd by registrar) JAN 7 1947 (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6 Jan 1947, at 9 30/A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4 Jan 1947 to 6 Jan 1947 and that I last saw h. l. alive on 6 Jan 1947

Immediate cause of death Gangrene Small intestine — Duration 4 da.

Due to Volvulus

Due to Congenital atresia of 1st 2nd portion of duodenum

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Gangrene Small Intestine Volvulus Congenital Atresia

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanley B Klyanow M. D.

Address Franklin Sq. Hosp. Date signed 1/6/47

G17251

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

108

G17254 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 8 mos.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 716 Vincent Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary E. Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Negro | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1st 1910

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 31 | 9 8 | 2 | hr. min. |

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Mack Campbell
13. Birthplace N. C.

MOTHER
14. Maiden Name Emma Lawrence
15. Birthplace N. C.

16 (a) Informant Margret Campbell
(b) Address 716 N. Vincent St.

17 (a) Burial (b) Date thereof 1/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co. Md.

18 (a) Funeral director Metropolitan Funeral Home Inc.
(b) Address 927 N. Mount St.

19 (a) JAN 7 1947 by registrar Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** January 3rd 1947 at 12 30 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 3rd 1947, to Jan 3rd 1947, and that I last saw her alive on Jan 2nd 1947

| Immediate cause of death | Duration |
|---|---|
| Right Lobar Pneumonia | 5 days |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Rt. middle & lower lobar Pneumonia

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James D. Carr M. D.
Address 515 Morben St Date signed 1.5.47

X

G47255

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 B

G47255

Registered No. _____

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3516 Lyndale Ave/
(c) Hospital or institution: 8r
(d) Length of stay in hospital or inst. (yrs., mos., or days) _____
(e) Length of stay in Baltimore (yrs., mos., or days) 16 Years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County _____
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3516 Lyndale Ave
(If rural give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

**3 (a) FULL NAME** Ivy Maude Yost

3 (b) If veteran, name war _____ | 3 (c) Social Security Account No. _____

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Andrew F. Yost
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1898

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 48 | 3 | 13 12 | _____ hr. _____ min. |

9. Birthplace Liverpool, England
(Town, county, and state)
10. Usual Occupation Salslady
11. Industry or business May Co. Department store

FATHER
12. Name William Silsby
13. Birthplace England

MOTHER
14. Maiden Name Sarah Traise
15. Birthplace England

16 (a) Informant Andrwe F. Yost
(b) Address 3516 Lyndale Ave-13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 8, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) _____ (Date rec'd by registrar) (b) _____ Registrar

JAN 7 1947

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH Jan. 5, 1947 19 , at 12:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-22- 1945 to 1-5- 1947 and that I last saw her alive on 1-5- 1947.

| Immediate cause of death | Duration |
|---|---|
| Generalised Carcinomatosis | 3 mos |
| Due to Probably gastric Cancer | 2 yrs |
| Due to _____ | _____ |
| Other Conditions _____ | _____ |

(Include pregnancy within 3 months of death)
Date of operation 10-1-45 & 12-2-46
Major findings of operation: No I- Pan-hysterectomy - multiple fibroid ~~of stomach~~ #2 - Exploratory

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide _____
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Milton C. Laney M. D.
Address 2117 Belair Rd Date signed 1-7-47

X

G47256

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G47256

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd St & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 908 St Paul St (If rural give location)
(e) Citizen of foreign country? Da (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine A. Flood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Wid

6 (b) Name of husband or wife Michael J. Flood

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 3, 1864

8. AGE: Years 82 | Months 1 | Days 3 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Michael Kenagan
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Connelly
15. Birthplace Scotland

16 (a) Informant Margaret Cronin
(b) Address 908 St Paul St, Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/47 (month) (day) (year)
(c) Cemetery St. Nicholas
Location Loudon Park

18 (a) Funeral director Henry W. Deane & Son
(b) Address 605 W Calvert St.

19 (c) JAN 7 1947 Huntington Williams, M.D. Registrar
Filed by registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1947, at 10:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 1946, to Jan 6 1947, and that I last saw h alive on 19

| Immediate cause of death | Duration |
|---|---|
| Cerebro-vascular accident | 3 hours |
| Due to Generalized arteriosclerotic Heart | |
| Due to | |
| Other Conditions Arteriosclerotic HD Bronchopneumonia | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. V. Lavenda, M.D. M. D.
Address U M H Date signed

VS 150 Via Pennsylvania R.R. — Escort Mrs. Margaret Corcoran

G47257

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

G47257 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5001 Cordelia Ave.
(c) Hospital or institution:

27 18

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5001 Cordelia
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** CONSTANCE A. MAAS

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widow |

6 (b) Name of husband or wife Louis O. Maas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 2 | 4 5 | hr. min. |

9. Birthplace New York, N. Y.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Reid
13. Birthplace N. Y.

MOTHER
14. Maiden Name Jennie (unknown)
15. Birthplace --

16 (a) Informant Mr. Louis Maas
(b) Address 5001 Cordelia Ave;

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS JAN 7 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 5, 1947, at 11:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1946 to Jan 5 1947, and that I last saw h[er] alive on 1-4 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage (Left Hemiplegia) | 9 ds |
| Due to Hypertension | years |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. B. Ensor M. D.
Address 4936 Park Heights Ave Date signed 1-6-47

X

G47258

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 183a

G47258 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 697 Gladstone Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 697 Gladstone Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** NORMAN E. SHAKESPEARE

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| World War #1 | 219-07-1823 |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Alverta M. Shakespeare
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Nov. 13, 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 1 | 22 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Druggist
11. Industry or business Overlea Pharmacy

FATHER
12. Name Warren Shakespeare
13. Birthplace California

MOTHER
14. Maiden Name Sarah J. Broughton
15. Birthplace Md.

16 (a) Informant Mrs. Alverta M. Shakespeare
(b) Address 697 Gladstone Ave. 10

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address

19 (a) JAN 7 1947 (Date rec'd by registrar) (b) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5, 1947 at 4:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to Jan 1947 and that I last saw h.. alive on Jan 5 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Helbeck M.D.
Address 5006 Roland Ave Date signed 6 Jan 47

G47259

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 164c

G47259 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Maryland General Hospital 2 D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 236 N. Monastery Street. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

**3 (a) FULL NAME** HENRY FINK

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: Nina Veronica Fink
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 13, 1902

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 44 | 9 | 22 | ..... hr. ..... min. |

9. Birthplace: Balto., Md. (Town, county, and state)
10. Usual Occupation: Fireman
11. Industry or business: Balto., City

MOTHER, FATHER
12. Name: HenryFink
13. Birthplace: Baltimore
14. Maiden Name: Annie L. Kempe
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mr. Donald P. Fink
(b) Address: 236 N. Monastery Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/47 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral Cem
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a)..... (Date rec'd by registrar) (b)..... Registrar

JAN 7 1947

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 5, 1947, at 10.20 P. M.

21. I certify that I took charge of the remains described above, held an insp.& inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Gunshot of Brain

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-5-47 at 10 p. M.
(b) Where did injury occur? 1529- Eutaw Place.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury: Firearms

23. Signature: Howard J. Madden M.D. Medical Examiner.
Date signed 1-6-47

X

617269

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 309

Registered No. 617260

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Oliver & Caroline
(c) Hospital or institution: St. Joseph's 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County —
(c) City or town Baltimore 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2038 Ellsworth St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Albert L. Morris

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Josephine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-24-1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 7 | 13 | hr. min. |

9. Birthplace Cumberland, Md.
(Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Camp Holabird

FATHER
12. Name David Morris
13. Birthplace Cumberland Md.

MOTHER
14. Maiden Name Hattie Ford
15. Birthplace West Va.

16 (a) Informant Josephine Morris
(b) Address 2038 Ellsworth St.

17 (a) Burial (b) Date thereof 1-8-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cem.
Location Mt. Olivet Hill Co.

18 (a) Funeral director John C. Malley Jr.
(b) Address 2435 E. Oliver St.

19 (a) JAN 7 1947 Huntington Williams M.D.
(Date received by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6/47 1947, at 12:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5/47 19 to 1/6/47 19, and that I last saw him alive on 1/6 1947.

| Immediate cause of death | Duration |
|---|---|
| Dissecting Aneurysm | |
| Due to Arteriosclerosis | |
| Due to HCVD | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Dissecting Aneurysm

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Melvin Lamonte
Address 1 So. Hoyt Date signed 1/6/47

VS 150

G47261

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 51 R

G47261 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address CALVERT AND SARATOGA Sts.
(c) Hospital or institution:
MERCY HOSPITAL 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 58 YRS

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County —
(c) City or town BALTIMORE 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2919 E. FEDERAL ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** JAMES M. SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Ella E. Smith

6 (c) If alive, give age 87 years

7. Birth date of deceased (mo., day, yr.) 12-29-1863

8. AGE: Years 83 | Months 0 | Days 7 | If less than one day hr. min.

9. Birthplace ENGLAND (Town, county, and state)

10. Usual Occupation NONE.

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace ENGLAND

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace ENGLAND

16 (a) Informant Ella E. Smith
(b) Address 2919 E. Federal St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-9-46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location North Ave

18 (a) Funeral director John E. Miller Jr.
(b) Address 2437 E. Oliver St

19 (Date rec'd by registrar) JAN 7 1947 Huntington Williams M.D. (Registrar)

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 1-6- 1947, at 6:45 A.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from NOV. 22 1946, to JAN 6 1947, and that I last saw HIM alive on JAN 6 1947.

Immediate cause of death CARDIO-VASCULAR COLLAPSE. — Duration

Due to CEREBRAL VASCULAR ACCIDENT.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11-28-46, 12-7-46

Major findings of operation: Hypertrophied prostate with adenocarcinoma.

of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature James A. Roberts M. D.

Address Mercy Hospital Date signed 1-6-47

VS 150

X

G47262

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 82a

G47262 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 512 N. Payson St.
(c) Hospital or institution: 20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28 years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 512 N. Payson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Herbert Hodges Trail

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-0191

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Bertie Trail
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 0 | 21 | hr. min. |

9. Birthplace Montgomery Co., Md. (town, county, and state)
10. Usual Occupation Mechanic
11. Industry or business Balto. Transit Co.

FATHER
12. Name Richard S. Trail
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Jane Hodges
15. Birthplace Md.

16 (a) Informant Mrs. Bertie Trail
(b) Address 512 N. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-9-47 (month) (day) (year)
(c) Cemetery or crematory Presbyterian Cem.
Location Frantz, Md.

18 (a) Funeral director C. Harry Weed
(b) Address Laytonsville, Md.

19 (a) (Date) (Signature) Huntington Williams, M.D.

JAN 9 [redacted]

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 6 1947 at 7:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-23- 1946 to 1-6 1947 and that I last saw h[illegible] alive on 1-6- 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary thrombosis | 9 days |
| Due to Gen. Arteriosclerosis | 2 yr. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Huntington Williams M. D.
Address 2424 Eutaw Place Date signed 1-6-47

X

G47263

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G47263

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yr

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2149 Hanford Rd.
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

**3 (a) FULL NAME** CATHERINE SCHMIDT

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| f | w | Widow |

6 (b) Name of husband or wife William A

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 10 | 13 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Nagel
13. Birthplace Germany

MOTHER
14. Maiden Name Sachtmann
15. Birthplace Germany

16 (a) Informant Wm R Schmidt Jr
(b) Address 4805 Edmondson Ave

17 (a) Burial (b) Date thereof 1/6/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Wilson & Dorsey
(b) Address 1711 Eutaw St

19 JAN 7 1947 (b) Registrar
(rec'd by registrar)

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5/47 19..... at 9:05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to HER death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?.....
(d) Means of injury.....

23. Signature John R Davis M.D.
Medical Examiner.

Date signed 1/6/47

G47264

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 126

G47264 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address CALVERT AND SARATOGA STS
(c) Hospital or institution:
MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 9 DAYS

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County Anne Arundel
(c) City or town ODENTON
(If outside city or town limits, write RURAL and give town)
(d) Street No. OLD ANNAPOLIS ROAD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MRS ARMINTA McCRACKEN.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | WIDOW |

6 (b) Name of husband or wife FRANK McCRACKEN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 9, 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 76 | 6 | 27 | hr. min. |

9. Birthplace NEW JERSEY.
(Town, county, and state)
10. Usual Occupation NONE.
11. Industry or business

FATHER
12. Name RICHARD SHAUGER
13. Birthplace NEW JERSEY

MOTHER
14. Maiden Name HESTER DEREMUS.
15. Birthplace NEW JERSEY.

16 (a) Informant Henrietta Stevens
Annapolis Rd - Odenton Md.

17 (a) Removal (b) Date thereof 1/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pompton Plains
Location New Jersey

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) (b)
(Date rec'd by) Registrar

JAN 7 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-6- 1947, at 7:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-28 1946, to 1-6 1947, and that I last saw her alive on 1-6 1947.

Immediate cause of death PERIPHERAL VASCULAR COLLAPSE — Duration

Due to UREMIA

Due to

Other Conditions CONGESTIVE HEART FAILURE
(Include pregnancy within 3 months of death)

Date of operations 12-29-46

Major findings of operations: GALL STONE OBSTRUCTING SMALL INTESTINE

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James A. Roberts M. D.
Address Mercy Hospital Date signed 1-6-47

X

G47265

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 194a

G47265 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1502 Eutaw Place
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1502 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Gates Via

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Mary Via
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30th 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 7 | 3 | hr. min. |

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Antique Dealer
11. Industry or business Own Business

FATHER
12. Name Unknown Via
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mary Via
(b) Address 1502 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/46 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Dorsey Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date received by local registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 3rd 1946 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 30 Nov 1945 to 3 JAN 1946 and that I last saw him alive on 2 JAN 1946

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | 5 weeks |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lloyd E. Taylor M. D.
Address 3902 Greenmount Ave. Date signed 6 Jan 46

X

G47266

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47266 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 773 McKewin Ave D. of A
(c) Hospital or institution:
9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 773 McKewin Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Krill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Emma Krill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 6th 1874

8. AGE: Years: 72 | Months: 7 | Days: 0 | If less than one day: hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: Engineer

11. Industry or business: Marine

12. Name: William Krill

13. Birthplace: Germany

14. Maiden Name: Unknown

15. Birthplace: Md

16 (a) Informant: Margaret Harrison

(b) Address: 3714 Rexmere Rd. Balto. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/47 (month) (day) (year)

(c) Cemetery ~~or crematory~~: Maryland Park

Location: Parkville Md.

18 (a) Funeral director: William Cook Inc.

(b) Address: 1217 St. Paul St

19 (a) Date rec'd by reg. (b) Washington Williamsport, Md

VS 181

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/6 1937 at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH a Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Tulbrusky M.D.
Medical Examiner.

Date signed 1/6/47

X

G47267

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

G47267 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 324 W - 29th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto - (If outside city or town limits, write RURAL and give town)
(d) Street No. 324 W - 29th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Miller

3 (b) If veteran, name war W. W. #1

3 (c) Social Security Account No. 212-12-6727

4. Sex M | 5. Color or race W | 6 (a) Single, ~~married~~, widowed, or divorced. Widowed

6 (b) Name of ~~husband or~~ wife Caroline Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 20th 1888

8. AGE: Years 58 | Months 4 | Days 15 | If less than one day hr. min.

9. Birthplace Altoona Pa. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or Balto. Paint & Color Works

12. Name (Unknown) Miller

13. Birthplace "

14. Maiden Name "

15. Birthplace "

16 (a) Informant Mrs. Frank Knowles

(b) Address 1418 W. Fayette St

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 1/9/47 (month) (day) (year)

(c) Cemetery ~~or crematory~~ U. S. National

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

19 (a) 1947 (Date rec'd by Reg'r) (b) Washington Williams, M.D. Registrar

VS 191

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 1947 at 10.00 P.M.

21. I certify that I took charge of the remains described above, held an Aug & Insp thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said ~~Autopsy~~, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature William G Hatfield M.D. Medical Examiner.

Date signed Jan 5, 1947

G47268

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH √111c

G47268 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 724 Lennox Street.
(c) Hospital or institution: 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 724- Lennox St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Noah (Reed) Shell Sowers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of ~~husband~~ or wife: Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 29th 1898

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 48 | 0 | 6 | hr. min. |

9. Birthplace Culpepper Va.
(Town, county, and state)

10. Usual Occupation Oiler

11. Industry or business Old Bay Line

FATHER
12. Name Jacob E. Sowers
13. Birthplace Va.

MOTHER
14. Maiden Name Rosie Ann Tutwiler
15. Birthplace Va.

16 (a) Informant Rosalie S. Rote
(b) Address 724 Lennox St.

17 (a) Removal (b) Date thereof 1/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Family Burial Ground
Location Culpepper Va.

18 (a) Funeral director William Cook Inc.
(b) Address [redacted] St. Paul St.

JAN 7 [redacted] (b)
(Date rec'd by registrar)

Huntington-Williamsport

VS 151

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan. 5, 1947, at 7.40 P M

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

**IMMEDIATE CAUSE OF DEATH** Edema of lungs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

**23. Signature** George A. Merrill M.D.
Medical Examiner.
Date signed 1-6-47

X

G47269

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 52B

Registered No. G47269

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address D.04.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3722 Old York Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles L. Boston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 18th 1892

8. AGE: Years 54 | Months 2 | Days 17 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Penna R.R.

12. Name George Boston

13. Birthplace Md.

14. Maiden Name Annie Murphy

15. Birthplace Unknown

16 (a) Informant Bernadine Keegan

(b) Address 3722 Old York Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/47 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Balto

Location " " Md.

18 (a) Funeral director Williams Cook Inc.

(b) Address 819 St. Paul St.

19 (a) (b) Huntington Williams, M.D. Registrar

JAN 7 1947

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6 1947 at 12 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. Feldman M.D.
Medical Examiner.

Date signed 1/6/47

X

64270

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

516

Registered No. 64270

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 2B
(d) Length of stay in hospital or inst. (yrs., mos., or days) 46 days
(e) Length of stay in Baltimore (yrs., mos., or days) 83 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore 2B
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 W. Saratoga Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Henry Neumann

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | widowed |

6 (b) Name of husband or wife Annie Louise nee Christ
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1863

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | - | 20 | hr. min. |

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Tailor before retiring
11. Industry or business

FATHER
12. Name August Neumann
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Mrs. Rosa R. Shipley
(b) Address 1809 W. Saratoga St.

17 (a) Burial (b) Date thereof 1/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director Harry H. Wiltze
(b) Address 4101 Edmondson Ave.

19 (a) Filed 1947 (b) [illegible] Williams M.D.
Registrar

JAN
VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** January 6 1947, at 9:45 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Jan 6 1947 and that I last saw him alive on Jan. 6 1947

Immediate cause of death Cardiac Failure — Duration

Due to acute & Chronic pyelonephritis

Due to

Other Conditions Hypostatic pneumonia

(Include pregnancy within 3 months of death)

Date of operation 12-2-37

Major findings of operation: Adenocarcinoma of prostate

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard G. Martin M. D.
Address Md. Gen. Hosp. Date signed 1-6-47

G47271

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47271 Registered No. 1701c

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 228 S. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Warren G. Forney

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 11 1919

8. AGE: Years 27 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Rigger

11. Industry or business

12. Name George F Forney

13. Birthplace Maryland

14. Maiden Name Maude L Kimbes

15. Birthplace Maryland

16 (a) Informant George F Forney

(b) Address 228 S. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 8 1947 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Woodlawn Md

18 (a) Funeral director Harry H Wyche

(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

JAN 7 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 5, 1947, at 6 a. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Crushed chest.

Ruptured heart and liver

Due to: Crushed face

Fracture of base of skull

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 20/6

(a) Date of injury 1-5-47 at about 5.30 a. M.

(b) Where did injury occur? 200 Blk N. Brunswick South side Frederick ave

(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No

(d) Means of injury Driver- struck pole Auto

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 1-6-47

G47272

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. G47272

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 432 N. Caroline st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 432 N. Caroline st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Louisa Churchville

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | colored | widowed |

6 (b) Name of husband or wife Richard Churchville
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | | | hr. min. |

9. Birthplace Nucumberland Cy. Va. (Town, county, and state)
10. Usual Occupation house wife
11. Industry or business

FATHER
12. Name Edmond Robinson
13. Birthplace Nucumberland Cy. Va.

MOTHER
14. Maiden Name Mary Ellison
15. Birthplace Nucumberland Cy. Va.

16 (a) Informant Carrie E. Jones
(b) Address 432 N. Caroline st.

17 (a) Burial (b) Date thereof 1/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lamet
Location Balto, Maryland

18 (a) Funeral director Mrs Sadie Bailey
(b) Address 1421 E. Jefferson st

19 (a) (b)
(Date rec'd by registrar)

JAN 7 1947 Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 1947, at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1946 to Jany 4 1947 and that I last saw h alive on Jany 4 1947

Immediate cause of death Hypertension — Cerebral Hemorrhage

Due to Arteriosclerosis and Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

| Duration |
|---|
| 4 Yrs |
| 4 Dys |

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. K. Walters M. D.
Address 1443 Eager Date signed Jan 6-47

X

7273

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 63B

Registered No. G47273

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Catonsville & Wilkens Avenue
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3132 WILKINS AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** DAISYE LEE SHOEMAKER.

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: BENJAMIN
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) FEB-5-1893

8. AGE: Years 53 | Months 10 | Days 29 | If less than one day ....hr. ....min.

9. Birthplace BALTIMORE MD
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER
12. Name ROBERT M. BROOKS
13. Birthplace WYOMING

MOTHER
14. Maiden Name CLARA BALL
15. Birthplace BALTIMORE MD

16 (a) Informant MR. BENJAMIN F. SHOEMAKER
(b) Address 3132 WILKINS AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

JAN 7 1947 (Date rec'd by registrar) Washington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 4 1947, at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/ 1946 to 1/3 1947 and that I last saw HER alive on 1/3 1947

| | Duration |
|---|---|
| Immediate cause of death: cerebral hemorrhage | 1 hr. |
| Due to: Hypertension | 3 yrs. |
| Due to: | |
| Other Conditions: Hypertension & Paget's Disease (Include pregnancy within 3 months of death) | 3 years |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hal Davenhaus M. D.
Address 1250 E. North Ave Date signed 1/4/47

VS 150

X

Birth certificate

G47274 G-67389

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 1161 c

G47274
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 513 So. Robertson St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Alice May Lumpkin

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5, 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | 3 hr. min. |

9. Birthplace South Balto. Gen'l Hosp. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Melvin Claudiana Lumpkin
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Alice May Mooney
15. Birthplace Baltimore Md.

16 (a) Informant (mother)
(b) Address 513 S. Robertson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St
18 (a) Funeral director John J. Duda
(b) Address 2829 Holdson St
19 (a) 1947 (Date rec'd by registrar) (b) [illegible]

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 5 1947, at 1:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5 1947 to 1/5 1947, and that I last saw h[illegible] alive on 1/5 1947.

Immediate cause of death: Respiratory failure, Acute Hemolytic Anemia
Due to: Hydrogen Peroxide
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Cohen M. D.
Address South Balto. Gen'l Hosp. Date signed 1/6/47

X

VS 150

G17275

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

G17275 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2652 Huntingdon ave.
(c) Hospital or institution:

12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2652 Huntingdon avenue
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** CATHERINE A BELZ

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| ---- | ----- |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | white | Widow |

6 (b) Name of husband or wife Ferdinand Belz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 3 | 5 | hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Peter Belz
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Kernan
15. Birthplace Ireland

16 (a) Informant Ferdinand Belz
(b) Address 2652 Huntingdon avenue

17 (a) Burial (b) Date thereof 1/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick road

18 (a) Funeral director Chas. L. Evans Son
(b) Address 118 W. Mt. Royal Ave

17 (a) 1947 (b)
(Date received by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 5 1947, at 7.15 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1943 to Jan 5 1947 and that I last saw h er alive on Jan 5 1947

Immediate cause of death

| | Duration |
|---|---|
| (a) Cerebral Hypocardites | wdy |
| Due to | |
| Due to | |
| Other conditions Arteriosclerosis & Chronic Nephritis | wdy |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. A. Richardson M.D.
Address 117 W. Saratoga St Date signed Jan 8 47

VS 150

G47276

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G47276 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1309 Park ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs?

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 Park ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Isabel Earle

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W. | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 30 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 2 | 7 | hr. min. |

9. Birthplace Centreville Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Dr Samuel T Early
13. Birthplace Queen Anne Co Md

MOTHER
14. Maiden Name Mary Isabel Ringgold
15. Birthplace Kent Co Md

16 (a) Informant Mrs Rose Earle Long
(b) Address 1309 Park ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan 9 1947 (month) (day) (year)
(c) Cemetery or crematory Welfield,
Location Centreville Md

18 (a) Funeral director Henry W Jenkins & Son
(b) Address McCulloh & Orchard Sts

19 (a) Date rec'd 1947 (b) Registrar Hampton Williams MD

JAN 7

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jany 6 1947, at 10 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jany 5 1941 to Jany 6 1947 and that I last saw h[illegible] alive on Oct 31 1946.

| Immediate cause of death | Duration |
|---|---|
| Coronary thrombosis (Myocardial infarct) | 1 day |
| Due to Coronary artery sclerosis Symptoms | 5 years |
| Due to Generalized arterio sclerosis Hypertension | 6 years + |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis P Hamburger M. D.
Address 1207 Eutaw Pl Date signed 1-7-47

X

G47277

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 33a

G47277 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1019 N. Wolfe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1019 N. Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Mary Elizabeth Nightower

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19 1898

8. AGE: Years 49 | Months 10 | Days 16 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Henry Harris
13. Birthplace Md.

MOTHER 14. Maiden Name Pinkney Jones
15. Birthplace Md.

16 (a) Informant Mildred Simpson
(b) Address 1032 N. Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 9 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. B. County Md.

18 (a) Funeral director Mrs. Gilbert A. Elliott
(b) Address 1129 N. Carrollton Ave.

19 (a) (b)
(Date received by registrar) Registrar

1 7 1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-5-47, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-19-46 to 1-5-1947 and that I last saw deceased alive on 1-3-1947.

Immediate cause of death: Bronchial Pneumonia, Duration 14 days
Due to Hypertension and Nephritis 3 Yrs
Due to Stippe
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jas. R. Blake M. D.
Address 1327 N. Carrollton Ave. Date signed 1-7-47.

X

G17278

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 186a

G17278 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County ----------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1842 Wilkins Ave. (If rural give location)
(e) Citizen of foreign country? ---------- (Yes or No)
If yes, name country ----------

3 (a) FULL NAME Anna Rogan

3 (b) If veteran, name war ----------

3 (c) Social Security Account No. ----------

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband ~~or wife~~ Lawrence J. Rogan
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) ---------- 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| About 80 | -- | -- | ---hr. ---min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business ----------

FATHER
12. Name John Fenhour
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Vernon
15. Birthplace Germany

16 (a) Informant Joseph H. A. Rogan
(b) Address 601 Winans Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. J. Meaney & Son
(b) Address 805 N. Calvert St.

19 (a) 1947 (Date) (b) Signature of registrar [illegible]

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6 1947 at 1 P.M 35

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5 1947 to 1/6 1947
and that I last saw her alive on 1/6 1947

| Duration |
|---|
| Immediate cause of death Respiratory Failure | |
| Due to Laceration Brain | about 4 Hrs |
| Due to Subdural Hematoma | |
| Due to Skull Fracture | |
| " Fall at Home | |

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 1/5/47
Major findings of operation: Fracture Skull, Subdural Hematoma, Lacerated Brain

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 19/4
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 1/4/47 at ? M
(c) Where did injury occur? Balto, Balto, Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? no (Specify type of place)
(e) Means of injury Fall on floors

23. Signature Peter V. Lyons M.D.
Address Bon Secours Hosp. Date signed 1/6/47

Howard J. Meaney, M.D. X

G47279 HEALTH DEPARTMENT—CITY OF BALTIMORE G47279

# CERTIFICATE OF DEATH 1318

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1341 N Carey 15 St., ..... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME George Brown

If U. S. Veteran specify WAR .....

(a) Residence: No. 1349 N Carey St., ..... Ward.
(Usual place of abode) (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3. Sex | 4. Color or Race | 5. Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | Colored | Widowed |

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Brown

6. DATE OF BIRTH (month, day, year) July - 1879

| 7. AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| 67 | 66 | 6 | | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. —

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —

10. Date deceased last worked at this occupation (month and year) — 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) Va.

FATHER

13. NAME Unknown

14. BIRTHPLACE (city or town) (State or country) Unknown

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country) Unknown

17. INFORMANT Etta Greville
(Address) 1349 N. Carey St.

18. BURIAL, CREMATION, OR REMOVAL
Place Mt Auburn Date 1/8 1947

19. UNDERTAKER Geo. H. Kelson
(Address) 503 Pulaski St.

20. FILED 1947 Huntington Williams, M.D. Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) January 6, 1947

22. I HEREBY CERTIFY, That I attended deceased from 12/25, 1946 to 1/6/47, 19....

I last saw h... alive on 1/5/47, 19.... Death is said to have occurred on the date stated above at ..... m.

The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Coronary Heart Failure | |
| Due to Myocardial Infarction | |
| Other contributory causes of importance: Hemiplegia | |

Was an operation performed? ..... Date of .....

For what disease or injury? .....

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify .....

(Signed) W. F. Hamby M. D.

(Address) 641 N Carey St

G47230

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47230 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 EASTERN AVE.
(c) Hospital or institution: City Hospitals. 4b
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3609 Foster (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** CHARLES J. THIEBES

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-5326

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife LUCY THIEBES

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) MAY 5, 1881

8. AGE: Years 65 | Months 8 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business MACHINIST.

12. Name JOSEPH THIEBES

13. Birthplace GERMANY.

14. Maiden Name HELEN ?

15. Birthplace GERMANY

16 (a) Informant LUCY THIEBES (WIDOW)

(b) Address 3609 FOSTER AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1-9-47 (month) (day) (year)

(c) Cemetery or crematory HOLY REDEEMER CEM.

Location 4200 BELAIR RD.

18 (a) Funeral director Charles S. Geiler.

(b) Address 3605 Fait Ave.

19 (a) ____ (Date of registration) (b) Clayton Williams M.D. Registrar

VS 15 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/5/47 19____, at 7:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to ____ death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ____ at ____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R. Dawson M.D. Medical Examiner.

Date signed 1/6/47

X

G47281

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G47281 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 1541

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4002 Fairview Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL MAZOR

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife Florence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | | | hr. min. |

9. Birthplace Baltimore Md (Town, county and state)
10. Usual Occupation merchant
11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Russia

MOTHER
14. Maiden Name Minnie
15. Birthplace Russia

16 (a) Informant Florence Mazor
(b) Address 4002 Fairview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-47 (month) (day) (year)
(c) Cemetery or crematory Beth Tefilo
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 1[illegible] Lafayette St

19 (a) 1947 (Filed by registrar) (b) [illegible] Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 6 1947, at 5 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29 1946 to Jan 6 1947 and that I last saw him alive on Jan 6 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary occlusion | 8 days |
| Cardiac failure | |
| Due to Arteriosclerotic Heart disease | |
| Due to | |
| Other Conditions Broncho pneumonia | 3 days |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roger Lee Brown M. D.
Address Sinai Hospital Date signed 1/7/47

Howard J. Walden M.D.

VS 150

G17282

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 F

G17282 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address CALVERT AND SARATOGA
(c) Hospital or institution:
MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 MO 4 DYS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE. (62 YRS.)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County
(c) City or town BALT.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3105 RUCKERT AVE.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country Russia

**3 (a) FULL NAME** IDA REISETT

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | S |

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14, 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 10 | 24 2/3 | hr. min. |

9. Birthplace BALT., MD.
(Town, county, and state)
10. Usual Occupation BUTLER BROS. EMPLOYEE
11. Industry or business

FATHER
12. Name JOSEPH RIESETT
13. Birthplace BALT., MD.

MOTHER
14. Maiden Name JENNY GUPINA
15. Birthplace BALT. MD.

16 (a) Informant Hospital Records
(b) Address Calvert & Saratoga Sts

17 (a) Burial (b) Date thereof 1-10-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Leonard J. Pugh
Address 5305 Harford Rd

19 (a) 1947 (b)
(Date rec'd by registrar) Huntington Williams, Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-7- 1947, at 8:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from JAN. 24 1946 to JAN 7 1947 and that I last saw her alive on JAN 7 1947.

Immediate cause of death RESPIRATORY FAILURE — Duration

Due to PRIMARY CARCINOMA OF LIVER WITH METASTASIS

Due to

Other Conditions ARTERIOSCLEROTIC HEART DISEASE.
(Include pregnancy within 3 months of death)

Date of operation 12-17-46

Major findings of operation: INOPERABLE CARCINOMA LIVER.

of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James A. Roberts M. D.
Address Mercy Hospital Date signed 1-7-47

G47283

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47283 Registered No. 186a

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Dunn 33rd + Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 Linganore Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

**3 (a) FULL NAME** Harry L Coffman

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Widowed |

6 (b) Name of husband or wife Maggie -
6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) 4-30-7[illegible]

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 8 | 8/6 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

**FATHER**
12. Name Harry Coffman
13. Birthplace Maryland

**MOTHER**
14. Maiden Name ?
15. Birthplace Maryland

16 (a) Informant Sydney W Coffman
(b) Address 6 Linganore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-9-47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) 1947 (Filed by registrar) [illegible] (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 1946 at 1:57 PM

21. I certify that death occurred on the date above stated; that I attended deceased from January 5 1946 to January 6 1946, and that I last saw h/his alive on January 6 1946

Immediate cause of death: Cardio-respiratory failure — Duration

Due to: Arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation 12-26-46
Major findings of operation: Ca of L. Kd Tumor
of autopsy: duodenal ulcer; arteriosclerosis

**PHYSICIAN**
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following as to date:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence November 26 1946 at 5 P M
(c) Where did injury occur? 6 Linganore Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell in room at home

23. Signature W Minister Turnbull, Jr. M. D.
Address Union Mem. Hospital Date signed 1-6-47

Howard J. Andrews, M.D.

VS 180

G17284 G17284

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 99

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1807 East 28th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-16
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 East 28th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** George L. Geyer
3 (b) If veteran, name war
3 (c) Social Security Account No. 213-01-8994

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Gertrude B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 8 - 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 11 | 29 | hr. min. |

9. Birthplace Maryland (Town, county and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Chas. P. Geyer
13. Birthplace Md.

MOTHER
14. Maiden Name Frederika Hoerner
15. Birthplace Balto Md

16 (a) Informant Mrs Gertrude B. Geyer
(b) Address 1807 E 28th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-47 (month) (day) (year)
(c) Cemetery or crematory Balto Cem. Co.
Location Balto. Md.

18 (a) Funeral director Leonard J. Burch
(b) Address 5305 Harford Rd.

19 (a) Filed by registrar (b) Registrar Washington Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6. 1947, at 2.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to 1-6 1947.
and that I last saw h. alive on 9-16 1946.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Embolism | Instant |
| Due to Thrombosis deep leg veins | 6 Months |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 7-23-46
Major findings of operation: Ligation Left femoral vein
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. W. Peake M. D.
Address 1127 N. Paul Date signed 1-6-47

VS 150

X

G17285

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G17285 Registered No. 4812

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1112 W. Mulberry St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

**3 (a) FULL NAME** ESTELLE B. LEE

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Colored | Married |

6 (b) Name of husband or wife Robert E. Lee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | 1 | 14 | hr. min. |

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Smith
13. Birthplace Va.

MOTHER
14. Maiden Name Fanny Smith
15. Birthplace Va.

16 (a) Informant Mr. Robert E. Lee
(b) Address 1112 W. Mulberry St.

17 (a) Burial (b) Date thereof 1-9-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem.
Location A. A. co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 528 W. Biddle St.

7 (a) 1947 (b) Washington Williams, M.D.
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6, 1947, at 4 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from 1/2 1947 to 1/6 1947 and that I last saw h[illegible] alive on 1/6 1947

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia (Terminal) | |
| Due to Carcinoma Uteri | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. Washington Williams
Address 1201 N. Carrollton Ave. Date signed 1/6/47

VS 150

647286

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46E

647286 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N. Carline
(c) Hospital or institution: St Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 72A (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** HERMAN G Rebbert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Barbara Rebbert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/23/77

8. AGE: Years 69 | Months 3 | Days 13 | If less than one day hr. min.

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name Theodore Rebbert
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Palmer
15. Birthplace Balto. Md.

16 (a) Informant Mrs August Riedel
(b) Address Edelphia Rd. at Golden Run

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 9 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Edmar W. Conklin & Son 924 E. Eager St.

18 (a) Funeral director
(b) Address Baltimore Md.

19 (a) (b)
(c) Date received by registrar 1947 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6 Jan 19 47 at 3:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 6 Jan 19 47. and that I last saw h. alive on 6 Jan 19 47.

Immediate cause of death CARCINOMAT OSIS — Duration

Due to CARCINOMA of CAECUM

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John B Weis MD
Address St Jos Hosp Date signed 1/7/47

Registrar

X

5 150

G47287

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 43a

G47287 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3027 Oakhill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3027 Oakhill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Maude Salina Mentzel

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 9, 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 3 | 26 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Henry D. Mentzel
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret Rumney
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. William L. Reisler
(b) Address 3027 Oakhill Ave.

17 (a) Burial (b) Date thereof Jan. 8, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Wilbur Lawrence
(b) Address 4510 Liberty Heights Ave.

JAN 7 1947 (a) (b)
Date rec'd (Registrar) Baltimore, Md.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 5 1947, at 10.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1930 to 1-5-1947
and that I last saw her alive on 1-5-1947.

Immediate cause of death Terminal Pneumonia — Duration 1 Day
Due to Paralysis - Throat — 5 Days
Due to Cerebral Hemorrhage — 5 Days
Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. W. Harper
Address 5201 Gwynn Oak Ave Date signed 1/6/47

G47288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G47288 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 63
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 S. Stockton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Rebecca Stanley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1894

8. AGE: Years 52 | Months SMT 7 | Days | If less than one day hr. min.

9. Birthplace Howard Co. Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

12. Name Unknown

13. Birthplace "

14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Sarah Payne

(b) Address 1071 W. Fayette Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 8, 1947 (month) (day) (year)

(c) Cemetery or crematory W.M. Auburn Cem

Location

18 (a) Funeral director Mrs Katie R. Gilligan

(b) Address 329 W. Lexington St.

19 (a) Date received 1947 (b) Registrar Huntington Williams Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-4- 1947, at 2 10 a M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.

Date signed 1-8-47

G17289 5 Cpe

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 96

Registered No. G17289

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Lafayette & Dukeland St
(c) Hospital or institution: West Balto Gen. Hosp 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County 4
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 S. Mount St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** AUBREY SIPE

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-07-9540

4. Sex M | 5. Color or race W | 6 (a) Single, (married) widowed, or divorced.

6 (b) Name of husband or wife Effie May Sipe

6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) April 14 1895

8. AGE: Years 51 | Months 8 | Days 21 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Cabinet maker

11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Henry Sipe
13. Birthplace Va

MOTHER
14. Maiden Name Berta Mohrhetter
15. Birthplace Va

16 (a) Informant Mrs Effie May Sipe
(b) Address 313 S Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/47 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem
Location Woodlawn Md

18 (a) Funeral director Geo L Beyer Jr
(b) Address 1512 Hollins St

(a) Williams, Mortician (b) JAN 7 1947 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 5 1947 at 9:03 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 4 1947 to Jan. 5 1947 and that I last saw him alive on Jan. 5 1947.

Immediate cause of death Cardiac Tamponade — Duration ? 1 day

Due to Rupture of arch of aorta — 4 days

Due to Idiopathic medial necrosis of aorta — ? years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation? No

of autopsy: Above.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard E. Blumenthal M.D.

Address WBJH Date signed 1/6/47

X

VS 150

G47290 BALTIMORE CITY HEALTH DEPARTMENT G47290
CERTIFICATE OF DEATH 131a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: The Sefton Institute 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) (27) 27 yrs. - 4 mo. - 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs. 4 mo. 22 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Cuba (b) County
(c) City or town Havana (If outside city or town limits, write RURAL and give town)
(d) Street No. #10-C-Street (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Cuba

3 (a) FULL NAME Louis Felipe Lopez Silvero y Oña

3 (b) If veteran, name war none
3 (c) Social Security Account No. none

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife Single
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-1-1888

8. AGE: Years 58 | Months 8 | Days 6 | If less than one day hr. min.

9. Birthplace Laguna La Grande Las Villas Cuba (Town, county, and state)

10. Usual Occupation employed in sugar business
11. Industry or business

FATHER
12. Name Jose Manuel Lopez Silvero y Vitia
13. Birthplace Santa Clara - Prov. Sta. Clara Cuba

MOTHER
14. Maiden Name Maria de Los Angeles de Oña y Pibalta
15. Birthplace Santa Clara - Prov. Sta. Clara Cuba

16 (a) Informant The Sefton Institute
(b) Address 6420 Reisterstown Road Baltimore 15, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan-18-1947 (month) (day) (year)
(c) Cemetery or crematory Colon Cemetery
Location Havana - Cuba

18 (a) Funeral director Guilbert & Mowen Co.
(b) Address 108 W North Ave.

19 (a) 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/7 1947, at 11 07 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 1946 to Jan 7 1947.
and that I last saw ... alive on 1/7 1947.

Immediate cause of death: Myocardial Infarct
Duration: 6 days
Due to: Repeated Epistaxis
Due to: Arteriosclerosis & hypertension
Due to:
Other Conditions: Leukopenia
Hemorrhagic type
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature L. Palagye M. D.
Address 336 North Gilmor St Date signed 1/7/47

VS 150

17291

BALTIMORE CITY HEALTH DEPARTMENT

BCH B80646 CERTIFICATE OF DEATH 159

Registered No. G17291

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 11-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 919 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Patricia Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/28/46

8. AGE: Years | Months | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business

FATHER 12. Name Richard Smith

13. Birthplace Md

MOTHER 14. Maiden Name Claudya Hankins

15. Birthplace Md

16 (a) Informant Claudya Smith

(b) Address 919 Madison Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School JAN 7 1947

18 (a) Funeral director Commissioner of Health

(b) Address

JAN 7 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 12-29 1946 at 7 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 19 to 12-29 1946.
and that I last saw h alive on 19

Immediate cause of death Pneumonia — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23.** Signature J. B. Harley, M.D.

Address Univ. Hosp. Date signed 1/6/47

VS 150

17292

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 92B

Registered No. G17292

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 9 York Court
(c) Hospital or institution: Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9 York Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Moore

3 (b) If veteran, name war No | 3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rosanna B. Moore

6 (c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1887

8. AGE: Years: 59 | Months: 11 | Days: 3 | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: Civil Engineer.

11. Industry or business: City Service.

FATHER
12. Name: John Moore
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Lucy Frost
15. Birthplace: Balto Md

16 (a) Informant: Robt S. Moore (Bro.)
(b) Address: 525 Park Av - Towson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 9-1947 (month) (day) (year)
(c) Cemetery or crematory: Dreid Ridge
Location: Ellicott City - Md.

18 (a) Funeral director: STEWART & MOWEN COMPANY
(b) Address: (W. F. WOODEN SUC.) 100 W. NORTH AVENUE

JAN 8 1947 (Date rec'd by Registrar)

VS 3

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 1947 at 10:30 P M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 31 1945 to Jan. 6 1947, and that I last saw him alive on Jan. 6 1947

Immediate cause of death: Myocarditis — Duration: 1 yr

Due to: Bacterial endocarditis — 18 mos.

Due to: /

Other Conditions: Mitral Stenosis — 3 to 5 yrs.

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Carlisle Taggart M. D.
Address: 3812 Greenmount Ave. Date signed: 1/6/47

X

17293

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 164E

Registered No. 17293

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hospital ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1142 Dutter St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

**3 (a) FULL NAME** ANNIE M. MESSENGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~ |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 9th 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 11 | 26 | ..... hr. ..... min. |

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

**MOTHER, FATHER**

12. Name Thomas Hanky

13. Birthplace Md.

14. Maiden Name Martha Wakeland

15. Birthplace Harford Co. Md.

16 (a) Informant Mrs Ruth Tracey

(b) Address 2732 Prospect st.

17 (a) Burial (b) Date thereof 1/9/47
(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Baltimore Co. Md

18 (a) Funeral director Wilson & Son

(b) Address 1[illegible] Ford St

19 (a) JAN 8 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Jan. 5, 1947, at 10:20 P.M.

**21.** I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH..... Fracture skull

Due to Crushed chest

Due to Fractured right humerus

Due to Fractured right clavicle

~~Other Conditions~~ Fractured left femur

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 1/5/47 at 10 P. M.

(b) Where did injury occur? City Hospital - Eastern Ave

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.

(d) Means of injury Fell from [illegible]

23. Signature George E. Merrill M.D.
Medical Examiner.

Date signed 1/6/47

VS 151

BC# G17294 #64053

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 567

G17294 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Lakeland & Raynor Aves
(c) Hospital or institution: West Baltimore Gen Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-7 da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 522 N. Gulden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy Benton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M. | W | S |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 30th 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 1 | 7 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Ernest J. Benton
13. Birthplace Md

MOTHER
14. Maiden Name Anna A. Wolff
15. Birthplace Baltimore, Md

16 (a) Informant Mr. Ernest J. Benton
(b) Address 522 N. Gulden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4701 Old Frederick Rd
18 (a) Funeral director John J. Howard & Son
(b) Address 941-03 Wallbrook St

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 8 1947 Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 6th 1947, at 8P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30 1946, to Jan 6 1947, and that I last saw h.i.M. alive on Jan 6 1947.

Immediate cause of death Post operative Shock — Duration

Due to

Due to

Other Conditions Septicemia? Cranial bone & Subgaleal cyst
(Include pregnancy within 3 months of death)

Date of operation Jan 6 1946

Major findings of operation: Operation of Cranial bones & Subgaleal Cyst

of autopsy: no autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Benson

Address West Balt. Gen Hosp Date signed 1/7/47 M. D.

G17295

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

52a Registered No. G17295

Found-2636 W.North Ave.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15-C
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Lumbar yard
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. [illegible]
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Phillip Dietz, Jr

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Nellie Dietz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 8th 1900

8. AGE: Years 46 | Months 8 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Phillip Dietz
13. Birthplace md.

MOTHER
14. Maiden Name Margaret Ament
15. Birthplace md.

16 (a) Informant Mrs Augustus Dietz
(b) Address Ellicott City Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-9-47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn Md

18 (a) Funeral director F.C. Higinbotham
(b) Address Ellicott City Md

19 (a) Filed by registrar JAN 8 1947 Registrar
(b) Recorded by registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6, 1947 at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cirrhosis of liver

Due to Hypernephroma of Kidney

Due to Dilatation of heart

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.

Date signed 1-7-47

G17296

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 166

G17296 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay, in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 138 Jackson Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Nina Veronica Fink

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Henry Fink
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1902

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 44 | 4 | 27 24 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Saleswoman
11. Industry or business Tasty Korn Shop

FAMILY
12. Name William Thompson
13. Birthplace Maryland
14. Maiden Name Mary Goldsborough
15. Birthplace Maryland

16 (a) Informant Mrs. Doris Horn - Daughter
(b) Address 138 Jackson Place

17 (a) Burial (b) Date thereof 1/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 8 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION** 20

20. DATE OF DEATH Jan. 5, 1947 at 10 P.M.

21. I certify that I took charge of the remains described above, held an insp.& inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gun shot wound of Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-5-47 at 10 p. M.
(b) Where did injury occur? 1529 Eutaw Place
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature Howard J. Weldas M.D.
Medical Examiner.
Date signed 1-6-47

VS 151

17297

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G17297 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 604 Linnard St.
(c) Hospital or institution:

16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Linnard Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** EDWARD GILLER

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Lula E. Giller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 8 | 5 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation retired Ice Dealer
11. Industry or business Arlington Ice Co.

FATHER
12. Name Charles Giller
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. George Knarr
(b) Address 118 S. Culver St.

17 (a) Burial (b) Date thereof 1/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PK. CEM.
Location BALTO., MD

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTO., MD.

19 (a) JAN 8 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 6, 1947, at 7:35a M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1945, to Jan 6, 1947, and that I last saw h~~im~~er alive on Jan 5 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary Occlusion | 10 day |
| Due to Cardio Vascular Disease | 13 Months |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elliott W Johnson M. D.
Address 1432 Hudnick Date signed 1/7/47

VS 150

X

47298

AB-107165

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 307

G47298

Registered No.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2017 Walbrook Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country.

3 (a) FULL NAME Margaret E. Sigafoose or Margaret Sigafoose

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | White | Married |

6 (b) Name of husband or wife Roger E. Sigafoose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14- 1899

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 47 | 1 | 23 | hr. min. |

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER

12. Name Charles Degenhart

13. Birthplace Maryland

MOTHER

14. Maiden Name Bertha Myers

15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/47 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) JAN 8 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Signature of registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7 1947, at 4.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-29- 1946, to 1-7 1947, and that I last saw h im alive on 1-7 1947

Immediate cause of death Hemorrhage from Esophageal Erosion.

Due to Secondary Hemorrhage of Arch of Aorta.

Due to Luetic Aortitis.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Alive

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Herbert R. Farber M. D.

Address Balto. City Hosps. Date signed 1-7-47

V S 150

G47299

G47299

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 52 B

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1405 Hollins Street.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State (b) County
(c) City or town 1405 Hollins St. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Robert Burt Yeager.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | 214 011480 |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Blanch Yeager
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March. 16. 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 9 | 19 | hr. min. |

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Del Tox Co.

FATHER
12. Name MOses Burt Yeager
13. Birthplace Pa.

MOTHER
14. Maiden Name Margaret Rickey.
15. Birthplace Pa.

16 (a) Informant Margaret Robbinson
(b) Address I405 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof I. 8. 1947 (month) (day) (year)
(c) Cemetery or crematory loudon Park.
Location Frederick Ave.

18 (a) Funeral director Robert L Brooks
(b) Address I338 Hollins Street.

19 (a) (Date received by registrar) JAN 8 1947 (b) Registrar Huntington Hollinsworth Address 9 E Mt Royal Ave Date signed 1-7-47 M. D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH January. 5 1947. at 2. p M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-8-1946 to January 4 1947. and that I last saw h. alive on Dec 0 1946.

| Immediate cause of death | Duration |
|---|---|
| Acute Cardiac dilation | |
| Due to Carcinoma of Bladder - with Metastases | |
| Due to | |
| Other Conditions Nephritis, Chr. | |

(Include pregnancy within 3 months of death)
Date of operation 7-22-46
Major findings of operation: Carcinoma of bladder -
of autopsy: not done -

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. G. Counsell M. D.

X

647300

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 83a

Registered No. 647300

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4109 Boarman ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) Hoyrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4109 Boarman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Clara E Krenfreis

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|

| Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Morris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | | | hr. min. |

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

**FATHER**
12. Name Leon
13. Birthplace Austria

**MOTHER**
14. Maiden Name Adelle
15. Birthplace Austria

16 (a) Informant Fannie Furchman
(b) Address 4109 Boarman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-8-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd + Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Balto St

19 (a) ...d by me Huntington Woodmont, Md

JAN 8 1947

MS 159

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/7 1947, at 9 50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/6 1947 to 1/7 1947.
and that I last saw h[illegible] alive on 1/6 1947

Immediate cause of death Cerebral Hemorrhage

Duration 2 days

Due to

Due to

Other Conditions High Blood Pressure & Emphysema
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: no

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury

23. Signature A. F. Hedrich M. D.
Address 7901 Gorsuch Rd

X 1/7/47

G47301

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 83a

Registered No. G47301

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County ---
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1562 E. Fort Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Frank A. Schwallenberg
3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife ---
6 (c) If alive, give age -- years
7. Birth date of deceased (mo., day, yr.) 6/17/1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 6 | 19 | ---hr. ---min. |

9. Birthplace Annapolis, Maryland (Town, county, and state)
10. Usual Occupation Roman Catholic Priest
11. Industry or business ---

FATHER
12. Name August Schwallenberg
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Bohn
15. Birthplace Germany

16 (a) Informant Mrs. Mary E. Kramer
(b) Address 14 Revell St. Annapolis

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/47 (month) (day) (year)
(c) Cemetery ####### St. Mary's
Location Annapolis, Maryland
18 (a) Funeral director H. H. Mears & Son
(b) Address 805 N. Calvert St.
19 (a) (Date rec'd by) (b) Registrar

JAN 8 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1947, at 11 45 M
21. I certify that death occurred on the date above stated; that I attended deceased from 1/6/47 19 to 1/6/47 19, and that I last saw him alive on 1/6/47 19.

| Immediate cause of death | Duration |
|---|---|
| Cerebral hemorrhage | |
| Due to General arteriosclerosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. N. Watts Jr M. D.
Address Bon Secours Hosp Date signed 1/6/47

X

G17303

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 122a

G17303 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 74yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Cator Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Parlett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/1/76

8. AGE: Years 70 | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Henry J. Parlett
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Mary Kenny
15. Birthplace Baltimore County

16 (a) Informant Clinton J. Parlett
(b) Address 905 Cator Ave. city

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/47 (day) (year)
(c) Cemetery or crematory Bath. Mem. Park
Location Eastern Ave. Balto.

18 (a) Funeral director John A. Sullivan
(b) Address 3008 E. Baltimore St.

19 (a) (Date received by registrar) JAN 8 1947 (Registrar's signature) Huntington Hollins

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 6 January 1947, at 10 45 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 23 Dec 1946, to 6 Jan 1947 and that I last saw her alive on 6 Jan 1947.

| | Duration |
|---|---|
| Immediate cause of death Cardio Respiratory failure | |
| Due to Arteriosclerosis, generalized | |
| Due to | |
| Other Conditions Diabetes mellitus Strangulated femoral hernia | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Strangulated femoral hernia

Autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton Jameson M. D.
Address 10 S. Howard Date signed

X

G17303

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. G17303

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1004 W Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) unk

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 W Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Elijah Booker

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | C | Married |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

| 8. AGE Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 6 | | hr. min. |

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Elijah Booker
13. Birthplace Va

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mary E. Booker
(b) Address 15-16 Preston alley

17 (a) Burial (b) Date thereof 1/10/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Presstman St

19 (a) (Date received by registrar) JAN 8 1947 (b) Registrar Huntington Williams

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-4-1947 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-4 1947 to 1-4 1947 and that I last saw h alive on 1-4 1947

| Immediate cause of death | Duration |
|---|---|
| Cardiovascular renal disease, | |
| Due to pulmonary edema | 6 mos. |
| Due to myocardial failure | 1 day |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. H. Laughton M.D.
Address 1 E Lexington St Date signed 1/7/47

# HEALTH DEPARTMENT—CITY OF BALTIMORE

G47301 CERTIFICATE OF DEATH 1937 G47304

Registered No.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1381 N. Gilmore St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. 6 da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Annie Brown

If U. S. Veteran specify WAR

(a) Residence: No. 1381 N. Gilmore St., Ward

(Usual place of abode) (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. Color or Race: Colored

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert Brown

6. DATE OF BIRTH (month, day, year): 1884

7. AGE: Years 63; Months —; Days —; If LESS than 1 day ... hrs. or ... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: —

10. Date deceased last worked at this occupation (month and year): —

11. Total time (years) spent in this occupation: —

12. BIRTHPLACE (city or town) (State or country): Maryland

MOTHER

13. NAME: Augusta Queen

14. BIRTHPLACE (city or town) (State or country): Maryland

15. MAIDEN NAME: Unknown

FATHER

16. BIRTHPLACE (city or town) (State or country): Maryland

17. INFORMANT: Alberton Lyle

(Address) 1381 N. Gilmore St.

18. BURIAL, CREMATION, OR REMOVAL

Place Arbutus Date 1/9 1941

19. UNDERTAKER: Geo. B. Gleason

(Address) 1303 Pulaski

20. FILED ..... 19..... Registrar.

JAN 8 1941 Huntington Williams

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): Jan 6, 1941

22. I HEREBY CERTIFY, That I attended deceased from December 8, 1940, to Jan. 6, 1941

I last saw h[illegible] alive on Jan 6 1941 Death is said to have occurred on the date stated above, at 2:00 P.m.

The principal cause of death and related causes of importance were as follows:

| | Interval between onset and death |
|---|---|
| Hyper Cerebral Hemorrhage | — |
| Other contributory causes of importance: Hypertensive Heart Disease | |

Was an operation performed? no Date of —

For what disease or injury?

Name of operation —

What test confirmed diagnosis? — Was there an autopsy? no

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19....

Where did injury occur? .....

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify .....

(Signed) H. Franklin Phillips M. D.

(Address) 1543 Penna. Ave

AB-107388 647305

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 82

Registered No. 647305

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1/2hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3111 Berkshire Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Norman Emory Griffith

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | White | Separated |

6 (b) Name of husband or wife Ella
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3- 1903

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 43 | 9 | 4 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Silas
13. Birthplace Va. ?

MOTHER
14. Maiden Name Ella
15. Birthplace Va. ?

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 10 46 (month) (day) (year)
(c) Cemetery or crematory Union Chapel Cem.
Location Harford Co. Md.

18 (a) Funeral director Tagsahn Funeral Home
(b) Address 7401 Belair Rd.

19 (a) (Date rec'd by registrar) (b) Registrar
Huntington Williams, M.D.

V S 150 JAN 8 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 7- 1947, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-7 1947 to 1-7 1947, and that I last saw him alive on 1-7 1947.

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia | |
| Due to Progressive Muscular Atrophy | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert R. Faber M. D.
Address Balto City Hosps Date signed 1-7-47

X

G17306

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G17306

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 752 E. Thirtieth St.
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 752 E. Thirtieth St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Martin G. Szeliga

3 (b) If veteran, name war ----------

3 (c) Social Security Account No. None

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Elizabeth B. Szeliga
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1901

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 45 | 10 | 25 | hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Grocer

11. Industry or business

FATHER
12. Name John Szeliga
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Martin G. Szeliga
(b) Address 752 E. Thirtieth St.

17 (a) Burial (b) Date thereof Jan. 9-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Maryland

18 (a) Funeral director Ellsworth Funeral
(b) Address 3911 Liberty Heights Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

JAN 10 1947 Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 1947, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1939, to Jan 5 1947 and that I last saw him alive on January 5 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary thrombosis | |
| Due to | |
| Due to | |
| Other Conditions Myocardial failure | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jack J. Szeliga M. D.
Address 506 E. North Ave Date signed 1-7-47

G17307

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G17307

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 610 N. Fremont Ave.
Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 N. Fremont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** George A. Mosby

3 (b) If veteran, name war II
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1911

8. AGE: Years 35 | Months 5 | Days 3 | If less than one day hr. min.

9. Birthplace Richmond, Va.
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name James E. Mosby
13. Birthplace Nelson County, Va.

MOTHER 14. Maiden Name Maggie Hobson
15. Birthplace Richmond Va

16 (a) Informant Audrey Mosby
(b) Address 610 N. Fremont Ave.

17 (a) Burial (b) Date thereof Jan. 9, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director Mrs Hattie R. Williams
(b) Address 322 N. Schroeder St

19 (a) (b) Registrar
(Date rec'd by reg.)

JAN 8 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5 1947 at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-2 1946 to 1-5 1947 and that I last saw h[illegible] alive on 1-3 1947.

Immediate cause of death Hypertension
Cardio Vascular
Due to Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

| Duration |
|---|
| 1 yr |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M. D.
Address 5-5 Druid Hill Ave Date signed 1-7-47

G47308

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1937 Registered No. G47308

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 765 W. Saratoga St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4'
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 765 W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amanda Green Freeland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: John Freeland
6 (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) June 30, 1873

8. AGE: Years 73 | Months 6 | Days 5 | If less than one day hr. min.

9. Birthplace Annapolis Md. (Town, county and state)

10. Usual Occupation Dressmaker

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Sarah Ann
15. Birthplace Annapolis Md.

16 (a) Informant Lillian Green
(b) Address 765 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 9, 1947 (month) (day) (year)
(c) Cemetery or crematory Brewer Hill Cem.
Location Annapolis Md.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registered

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 1947 at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-25-1946 to 1-3-1947 and that I last saw h alive on Jan 3 1947

Immediate cause of death: Cerebral Thrombosis

Due to: Arteriosclerosis Duration: Yrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 765 W. Saratoga St. Date signed 1-7-47

V S 150

JAN 8 1947

Huntington Williams, Registrar

G17309

JL - 107195

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH .13B

G17309 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1420 Wilmer Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Butler

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | Widower |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28, 1903

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 43 | 9 | 5 | hr. min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Jim Butler
13. Birthplace Md.

MOTHER
14. Maiden Name Katie Thomas
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/8/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A A Co Md

18 (a) Funeral director Daniel J Brown
(b) Address 1250 Montgomery St

8 (a) 1947 (Date filed by registrar) Registrar Hampton Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 2 1947 4.40P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 30 1946 to Jan. 2 1947, and that I last saw h im alive on Jan. 2 1947

| Immediate cause of death | Duration |
|---|---|
| Respiratory Failure | |
| Due to Multiple Lung Abscess | |
| Due to | |
| Other Conditions Malnutrition (Include pregnancy within 3 months of death) | |
| Date of operation | |
| Major findings of operation: | |
| of autopsy: Same as above | |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address Balto City Hosp Date signed 1-8-47

G17310
503800

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 153

G17310
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State N. J. (b) County
(c) City or town Hillside (If outside city or town limits, write RURAL and give town)
(d) Street No. 1525 Keeler St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Harriet Harrison

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-[illegible]36

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 11 | 4 | 7 | hr. min. |

9. Birthplace N. J. (Town, county, and state)
10. Usual Occupation student
11. Industry or business

FATHER
12. Name Daniel Harrison
13. Birthplace ? Latvia

MOTHER
14. Maiden Name Ruth Harrison
15. Birthplace N. J.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/47 (month) (day) (year)
(c) Cemetery or crematory Beth David
Location Kenilworth, N. J.

18 (a) Funeral director John A. Mitchell-Sons
(b) Address 1900 Eutaw Place

19 (a) 1947 (Date rec'd by registrar) Huntington Williams Mort.

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH Jan - 8 1947 at 1225 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1946 to Jan - 8 1947 and that I last saw h[illegible] alive on Jan - 8 1947.

Immediate cause of death: Myocardial failure
Pulmonary edema
Due to Lupus Erythematosus disseminata

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

| Duration |
|---|
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George H Palmer
Address Johns Hopkins Hosp Date signed 1-8-47

VS 150

G47311

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47311
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Dun
(c) Hospital or institution: John Hopkins Hospital 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3909 Bonner Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Albert Knatz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/20/81

| AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 1 | 17 | hr. min. |

8. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation installment furniture

11. Industry or business

12. Name Phillip Knatz

13. Birthplace Germany

14. Maiden Name Christina Scheiner

15. Birthplace Germany

16 (a) Informant Albert F. Knatz (deceased, above)

(b) Address 3909 Bonner Road

17 (a) Burial (b) Date thereof 1/9/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Loudon Park

Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.

(b) Address 1900 Eutaw Place

JAN 8 1947
(Date rec'd by Registrar) Thurlington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/2 1947, at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. D. Lubrinske M.D.
Medical Examiner.
Date signed 1/2/47

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

17312

Registered No. 17312

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Avara, (Samuel) Salvatore

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | No |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Sadie
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | | | hr. min. |

9. Birthplace Italy (Town, county and state)
10. Usual Occupation Fruit Dealer
11. Industry or business Independent

FATHER
12. Name Lizzon Avarca
13. Birthplace Italy

MOTHER
14. Maiden Name Anetta Messina
15. Birthplace Italy

16 (a) Informant Sam Avara
(b) Address 606 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 9-1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Old Frederick Rd.

18 (a) Funeral director Joseph Lanza & Son
(b) Address 201 S. Lemmon Ave.

19 (Date received by registrar) JAN 8 1947 Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-#6 1947 at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27 1946 to 1-7 1947.
and that I last saw him alive on 1-#6 1947.
Immediate cause of death Cardiac failure

| Duration |
|---|
| |
| |
| |
| |
| |

Due to Arteriosclerotic CVD
Due to Diabetes mellitus
Other Conditions Abscess of back

(Include pregnancy within 3 months of death)
Date of operation 12-28-46
Major findings of operation: Abscess of back incised & drained
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. L. Couch, M.D.
Address University Hosp Date signed 1-6-47 M.D.

VS 150

G17313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G17313

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4101 N. Rogers Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2-1/2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4101 N. Rogers Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Franks Womble

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Emma G. Womble

6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) May 6, 1865

8. AGE: Years 81 | Months 8 | Days 1 | If less than one day hr. min.

9. Birthplace Raleigh, N. C.
(Town, county, and state)

10. Usual Occupation Retired-Agent

11. Industry or business Blue Ridge RR

FATHER
12. Name Jordan Womble
13. Birthplace North Carolina

MOTHER
14. Maiden Name Amy Knight
15. Birthplace North Caroline

16 (a) Informant Mrs. Emma G. Womble
(b) Address 4101 N. Rogers Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 9, 1947 (month) (day) (year)
(c) Cemetery or crematory Greenwood Cemetery
Location Dunn, N. C.

18 (a) Funeral director Wolfe Lamorelle
(b) Address 4510 Liberty Heights Ave.

19 (a) Filed by registrar JAN 8 1947 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7 1947, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 22 1946 to Jan 6 1947, and that I last saw him alive on Jan 6 1947.

Immediate cause of death — Kidney failure

Due to Hemorrhage and Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos R Abbott M. D.

Address 4509 Liberty Hgts Ave Date signed

VS 190

AB-102824 B 47214

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

B 47314 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 4-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5mos- 25days
(e) Length of stay in Baltimore (yrs., mos., or days) 8yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 747 Vine St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Rich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15-1880

8. AGE: Years 66 | Months 9 | Days 22 | If less than one day ....hr. ....min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Henry Lucas (D

13. Birthplace Va.

MOTHER 14. Maiden Name ? Haney

15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals Records

(b) Address 4940 Eastern Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-11-47 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location

18 (a) Funeral director George G. Nelson

(b) Address 1303 Pennsylvania Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

JAN 8 1947

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7- 1947, at 5.20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-12- 1946, to 1-7 1947, and that I last saw her alive on 1-7- 1947.

Immediate cause of death Coronary Occlusion — Duration 1 day

Due to Arteriosclerotic Heart Disease — Duration yrs.

Due to — Duration

Other Conditions Hypertension — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. E. Robinson Jr.

Address Balto City Hosp Date signed 1-8-47 M.D.

X

G47315

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G47315 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address D.A.
(c) Hospital or institution: West Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4123 Park Hgts Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John B. Minotti

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| None | 212-01-1176 |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Mary Minotti
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 26 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 5 | 12 | hr. min. |

9. Birthplace Larino Italy
(Town, county, and state)
10. Usual Occupation Clothing Cutter
11. Industry or business Haas Tailoring Co.

FATHER
12. Name Michele Minotti
13. Birthplace Italy

MOTHER
14. Maiden Name Marianna
15. Birthplace Italy

16 (a) Informant Frederick M. Minotti (Son)
(b) Address 4123 Park Heigts Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof January 11/47 (month) (day) (year)
(c) Cemetery ~~xxxxxxxx~~ Holy Redeemer
Location Belair Rd. Baltimore Md.
18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.
19 (a) JAN 8 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/7 1947 at 6 45 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. M. Sobieski M.D.
Medical Examiner.
Date signed 1/7/47

VS 191

To be approved by Med. Examiner

D.O.A G17316

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 124 B

Registered No. G17316

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 Alicanna St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

**3 (a) FULL NAME** Marie D. Sracke or SIERACKI

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband ~~or wife~~ Joseph Sracke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 8 1908

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 38 | 10 | 29 | hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Peter Alszewski
13. Birthplace Poland

MOTHER
14. Maiden Name Anthonia Philipowitz
15. Birthplace Poland

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Jan. 9 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) JAN 9 1947 (b) Huntington Williams M.D. Registrar

VS 150

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH Jan. 7 1947, at 1. M

21. I certify that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death DEAD ON ARRIVAL
GASTRO-INTESTINAL HEMORRHAGE — Duration #24 HRS.

Due to.....

Due to.....

Other Conditions CIRRHOSIS of LIVER ?

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....

of autopsy: Dr. Abell

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature J. Maxwell Williams M. D.
Address Johns Hopkins Hosp. Date signed 1-7-47

For S. J. R. Davis, by Howard J. Moeller, M. D. X

AB-107144 G47317 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G47317

# CERTIFICATE OF DEATH 13B

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 407 McAllister St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Serah Elizabeth Matthew

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | C | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1-1913

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 33 | 4 | 5 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles
13. Birthplace Maryland

MOTHER
14. Maiden Name Flossie Swann
15. Birthplace Maryland

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 11 47 (month) (day) (year)
(c) Cemetery or crematory Int. Calvery Cem
Location AA County
18 (a) Funeral director Lottie Gross
(b) Address 1408 Ashland Ave
19 (a) (Date rec'd by registrar) (b) Registrar

V S 15 JAN 8 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6 1947, at 3.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-28 1946 to 1-6 1947, and that I last saw h. alive on 1-6 1947.

Immediate cause of death: Pulmonary Tuberculosis, Far Advanced — Duration 6 mos.
Due to
Due to
Other Conditions: Uterine Peritonitis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [redacted]
Address Baltimore City Hospitals Date signed 1-7-47 M. D.

Hamilton for Williams, M.D.

AB-107869 G47318 J

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13 B

Registered No. G47318

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1hr-10min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1347 James Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Howard John Tellis Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-12-0191

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | White | Separated |

6 (b) Name of husband or wife Hazel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8- 1909

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 37 | 5 | 13 28 | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Howard John Tellis
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Barbara Limmer
15. Birthplace Baltimore, Maryland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN 9 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 BELAIR ROAD

18 (a) Funeral director MARTIN W.E. DIPPEL'S SONS
(b) Address LOMBARD & ANN STS

19 (a) (Date rec'd by registrar) JAN-8 1947 (b) Kathryn [illegible] Williams M

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6- 1947, at 5.20PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6- 1947, to 1-6- 1947, and that I last saw him alive on 1-6- 1947

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Tuberculosis; Far Advanced. | |
| Due to | |
| Due to | |
| Other Conditions Malnutrition | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: none autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund Baetjer M. D.
Address Balto City Hosp Date signed 7 Jan 47

To be approved by Medical Examiner Howard J. Mueller, M. D.

G47319

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48B

Registered No. G47319

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 109 S. Regester St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 74

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 109 S. Regester St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Margaret LasKarn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife George

6 (c) If alive, give age 86 years

7. Birth date of deceased (mo., day, yr.) April 7 1870

8. AGE: Years 76 | Months 9 | Days 0 | If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Charles Luckart

13. Birthplace Germany

MOTHER 14. Maiden Name Margaret Amschler

15. Birthplace Germany

16 (a) Informant George LasKarn

(b) Address 109 S. Regester St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN 11 AUT (month) (day) (year)

(c) Cemetery or crematory HOLY REDEEMER

Location 4300 BELAIR ROAD.

18 (a) Funeral director MARTIN WM. DIPPEL'S SONS

(b) Address 7110 BELAIR ROAD.

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

VS 190 JAN 8 1947 Huntington Williams

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 1947 at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Jan 7 1947, and that I last saw her alive on Jan 7 1947

| Immediate cause of death | Duration |
|---|---|
| CARCINOMA (uterus) | 2 YRS. |
| Due to | |
| Due to | |
| Other Conditions ARTERIOSCLEROSIS GR 1ST. MCRH | 5 YRS |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas F. Kavanagh M.D.

Address 3324 Hill Rd. Date signed 1-8-47

X

G17320 — 94a — G17320

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G17320

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 227 S Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 227 S Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Elizabeth M. Oldewurtel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F. | W. | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 29 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 71 | - | 9 | hr. min. |

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation At Home.
11. Industry or business

FATHER
12. Name Henry Oldewurtel
13. Birthplace Germany

MOTHER
14. Maiden Name Ursula Hatzold
15. Birthplace Germany

16 (a) Informant Marie Oldewurtel
(b) Address 227 S. Broadway

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1 13 47 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location 4300 BELAIR ROAD

18 (a) Funeral director MARTIN W.E. DIPPEL'S SONS
(b) Address LOMBARD + ANN STS

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 8 1947 at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1946 to Jan 8 1947 and that I last saw her alive on Jan 7 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | 1 wk. |
| Due to Coronary Atherosclerosis & Chr. Hypertension | 7 |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 700 W Pratt Date signed 1/8/47

VS 150 JAN 8 1947 Huntington Williams, M.D.

X

G17321

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G17321 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address ~~No~~ Monument St
(c) Hospital or institution: Sinai Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1633 E Balto St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Snyder

3 (b) If veteran, name war —
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | married |

6 (b) Name of husband or wife Annie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Isaac
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Next Of Kin
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-10-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc.
(b) Address 1439 E. Balto St

19 (a) Filed by registrar (b) Huntington Hillcrest, Md.

JAN 8 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6, 1947, at 9:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5, 1947, to Jan 8 1947, and that I last saw him alive on Jan 6, 1947

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure | |
| Due to Coronary thrombosis & | |
| angina pectoris | |
| Due to Hypertension & arterial | |
| arteriosclerotic heart disease | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney Greene
Address Sinai Hospital Date signed 1/8/47 (M. D.)

G47322 G47322

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

832a

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1322 E. Marth Ave.
(If rural give location)
(e) Citizen of foreign country? Yes or (No)
If yes, name country

**3 (a) FULL NAME** Spencer Holsey Parks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 48 | Months | Days | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Service Manager

11. Industry or business

FATHER
12. Name Cornelius Parks
13. Birthplace Va.

MOTHER
14. Maiden Name Missouri Barnes
15. Birthplace Va.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof Jan 4th (month) (day) (year)
(c) Cemetery or crematory Liberty
Location Parkley
18 (a) Funeral director Fred G Matt
(b) Address Belle Haven

19 (a) JAN 8 1947
(Signature of registrar) Hattie for Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 1 — 2 1947 3:00 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from 12-21 1946 to 1-2 1947, and that I last saw him alive on 1-2 1947.

Immediate cause of death: Respiratory failure — Duration

Due to: Subarachnoid Hemorrhage

Due to: Probable congenital Berry Aneurism + hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature H. Hattenbach M. D.
Address University Hospital Date signed 1-2-47

17323 Birth Certificate G-47296

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

160a 1

Registered No. G17323

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 2

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Carroll Co.
(c) City or town Baltimore Lutherville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route #2
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy Becklehimer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/6/47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 21 | hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name John C. Clyde Becklehimer
13. Birthplace Maryland

MOTHER
14. Maiden Name Cora Virginia Bridges
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (b) Date thereof 1-9-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Brandenburg
Location Berrett, Carroll Co. Md.

18 (a) Funeral director E. M. Walter
(b) Address Winfield, Md.

19 (a) (Date rec'd by Local Registrar) 1947 (b) Registrar Hampstead Md.

JAN 9 1947

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 1/7 1947, at 3:28 M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 1/6 1947 to 1/7 1947 and that I last saw him alive on 1/7 1947.

Immediate cause of death: Intracranial hemorrhage — Duration

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation —

of autopsy: None performed

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury —

23. Signature Herbert J. Sheeder M.D.

Address St. Agnes Hosp. Date signed 1/7/47

~~127324~~ BALTIMORE CITY HEALTH DEPARTMENT ~~X~~ ✓ 127324 Registered No.

# CERTIFICATE OF DEATH 119a

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore - Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 - B. Hamilton Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leon CALLAWAY ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/18/46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 1 | 7 12 | hr. min. |

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 8 1947
Commissioner of Health

18 (a) Funeral director
(b) Address

19 JAN 9 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 30, 1946, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Infantile diarrheal enteritis.
Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 12/30/46

VS 151

X

7325

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G47325
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 9-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1day hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (roomer) (If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 E. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1847

8. AGE: Years 49 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 8 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 9 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26, 1946, at 9.45 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary artery disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 12-26-46

VS 151

7326 BCH G63365

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1192 G47326 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 600 S. Eutaw St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 S. Eutaw St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Emma Marie Johnson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1946

8. AGE: Years | Months: 1 | Days: 20 30 | If less than one day: hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School

18 (a) Funeral director
(b) Address

19 JAN 9 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

JAN 8 1947
Commissioner of Health

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** January 2 1947, at 1:20 P.M.

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Infantile enteritis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 1/3/47

VS 151

7327

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. 947327

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 34 N. Bruce St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 34 N. Bruce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

2-(a) FULL NAME ALEXANDER WAMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 66 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER OF FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Locale Johns Hopkins Medical School JAN 8 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 JAN 9 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/24/46 19 , at 2:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Lewis M.D.
Medical Examiner.
Date signed 1/24/46

VS 191

G47328

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

Registered No. G47328

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1914 W. Lanvale St.
(c) Hospital or institution:

16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1914 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ROBERT L. SHORES

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Lillie E. Shores
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 2 | 18 | hr. min. |

9. Birthplace Deals Island
(Town, county, and state)
10. Usual Occupation Retired Insurance
11. Industry or business

FATHER
12. Name Levin Shores
13. Birthplace Deals Island

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. Norman L. Shores
(b) Address 2526 Arunah Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/11/47 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 9 1947 (Date rec'd by registrar) Huntington Williams, M.D. (b) Address 612 N. Eutaw St. Date signed

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 8, 1947, at 7:20A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1947 to June 7 1947.
and that I last saw h alive on 19

Immediate cause of death Cerebral Hemorrhage

| Duration |
|---|
| |

Due to

Due to

Other Conditions Angina

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Evans M. D.

Date signed

VS 150

X

G47329

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

937

G47329

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address North and Ellamont Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3013 Lyttleton Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** James E. Parnelle, Sr.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Margaret Rose Parnelle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 10 | 0 | hr. min. |

9. Birthplace South Carolina
(Town, county, and state)
10. Usual Occupation Manager
11. Industry or business National Central Bank

FATHER
12. Name Hampden Parnelle
13. Birthplace S. C.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. M. Rose Parnelle, Sr., Wife
(b) Address 3013 Lyttleton Rd.

17 (a) Burial (b) Date thereof 1/10/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.,
Location Washington, D. C.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) JAN 9 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/7 1947 at 8:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Tickner M.D.
Medical Examiner.
Date signed 1/8/47

G47330

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G47330 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4128 Parkside Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4128 Parkside Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** IDA MAY KRIES

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife George R. Kries
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 8 | 1 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Scharf
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ida E. Upperman
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. George R. Kries
(b) Address 4128 Parkside Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/11/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 9 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7, 1947, at 11:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1946 to Jan 7 1947.
and that I last saw h[illegible] alive on Jan 6 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | Sudden |
| Due to Arteriosclerotic Cardiovascular Disease. | |
| Due to | |
| Other Conditions Diabetes Mellitus. | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph D. Blum
Address 1206 E. Preston St. Date signed 1/8/47 M.D.

VS 150

939

347331

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 937 ✓

Registered No. G17331

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1120 Argonne Drive
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Va. (b) County Matthews
(c) City or town Moon P.O.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** LULA MAY BOHANNAN

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Thomas J. Bohannan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 7 | 13 | hr. min. |

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. B. Renshal
13. Birthplace Harford Co., Md.

MOTHER
14. Maiden Name Margaret Goldey
15. Birthplace Pa.

16 (a) Informant Mrs. J. Byrd Norris
(b) Address 1120 Argonne Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JAN 9 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-7-1947, at 6:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1946 to 1-7 1947, and that I last saw h[illegible] alive on 1-7 1947.

| Immediate cause of death | Duration |
|---|---|
| Arteriosclerosis | several years |
| Due to Hypertension | |
| Due to Chr. Myocarditis | |
| Other Conditions Age | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hubert C. Blake M. D.
Address Med Arts Bldg Date signed

X

47332

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G47332 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1210 N. Bentalou St.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

16 5

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 N. Bentalou St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** CHARLES EDGAR GEISELMAN

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widower |

6 (b) Name of husband or wife Viva M. Geiselman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 5 | 2 | hr. min. |

9. Birthplace Beaver Dam, Frederick Co., Md. (Town, county, and state)
10. Usual Occupation Insurance Salesman
11. Industry or business Prudential Life Ins. Co.

FATHER
12. Name Will Geiselman
13. Birthplace Frederick Co., Md.

MOTHER
14. Maiden Name Laura Stitley
15. Birthplace Frederick Co., Md.

16 (a) Informant Mrs. Louise Foos
(b) Address 638 Wildwood Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/9/47 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (b) JAN 9 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 7, 1947, at 5:30a M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 30, 1946, to Jan. 7, 1947, and that I last saw h im alive on Jan. 3, 1947

| Immediate cause of death | Duration |
|---|---|
| CHRONIC MYOCARDITIS | |
| Due to Hypertensive Cardio Vascular Disease | 2 years |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation --
Major findings of operation: --
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide none
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melvin H. Borden M. D.
Address 2030 W. FAYETTE ST Date signed 1/7/47

X

G47333

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 B

Registered No. G47333

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City.
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 ½ yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** Joseph Strassell

3 (b) If veteran, name war: | 3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife:

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 7 4 | 27 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Frank Strassell
13. Birthplace Germany ?

MOTHER
14. Maiden Name Clara Elmger
15. Birthplace ?

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street

17 (a) Burial (b) Date thereof Dec 10. 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St Baltimore, Md.

19 (a) Filed Dec 9 1947 (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan - 8 - 1947, at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 - 1946, to Jan 8 - 1947, and that I last saw him alive on Jan 7 1947.

| Immediate cause of death | Duration |
|---|---|
| Metastasis to Lung - | 2 weeks |
| Due to Carcinoma Stomach | 4 months |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E North Ave Date signed 12/9/47

VS 3

X

G47334

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. G47334

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Mt. Claire Shops-B & O R.R.
(c) Hospital or institution: Arlington Ave. & Pratt St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 Wilkens Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** WILLIAM O. GAUSE

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Sophia K. (Birx)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 1 | 13 | hr. min. |

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Carman
11. Industry or business B. & O. R. R.

MOTHER'S MAIDEN
12. Name Frederick Gause
13. Birthplace Germany

14. Maiden Name Pauline Junker
15. Birthplace Germany

16 (a) Informant Mrs. Sophia K. Gause
(b) Address 1617 Wilkens Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 9 47. (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location 3310 Taylor Ave.

18 (a) Funeral director Harry A. Nitzke
(b) Address 4101 Edmondson Ave.

19 JAN 9 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 6, 1947, at 3.40P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Moderate Hypertrophy of Heart
Coronary Disease
Generalized arteriosclerosis
Due to Congestion & Edema of Lungs
Nephrosclerosis
Other Conditions Cerebral Congestion
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-6-47 M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Waldeis M.D. Medical Examiner.
Date signed 1-7-47

47335
AB-106916

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 124a

Registered No. 47335

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20days
(e) Length of stay in Baltimore (yrs., mos., or days) 55yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2518 E. Monument St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Frank Kormann

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-22-7073

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | White | Married |

6 (b) Name of husband or wife Minnie F. nee Stein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 3 | 7 | hr. min. |

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Gerhart Korman
13. Birthplace Germany

MOTHER
14. Maiden Name Lizetta
15. Birthplace Germany

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 10 '47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore Highways

18 (a) Funeral director Harry H. Wilson
(b) Address 4101 Elmondawn Ave.

19 (a) JAN 9 1947 (Date rec'd by Registrar) (b) Washington Williams M.D.

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7- 1947, at 8PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17 1946 to 1-7 1947, and that I last saw him alive on 1-7 1947.

Immediate cause of death Esophageal Hemorrhage — Duration

Due to Laennec's Cirrhosis

Due to

Other Conditions Jaundice. Multiple Avitaminosis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert A. Farber M. D.
Address Balto City Hosps Date signed 1-7-47

X

7336

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

93D

Registered No. G47336

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 51
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8- 9- 0-
(e) Length of stay in Baltimore (yrs., mos., or days) 44 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 135 N. High Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Jack Raney

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Widower |

6 (b) Name of husband or wife Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4-1864

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | 10 | 0 | hr. min. |

9. Birthplace South Carolina
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name David Raney
13. Birthplace South Carolina

MOTHER
14. Maiden Name Rachel ?
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 9 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 9 1947 (Date rec'd by registrar) Hunter for Williams M.D.

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH January 4 1947, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 4 1938, to Jan. 4 1947, and that I last saw him alive on Jan. 4 1947

Immediate cause of death Cardio Bronchopneumonia — Duration 2 days

Due to

Due to

Other Conditions Arteriosclerosis Heart Disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.
Address Balto City Hosp Date signed 1/8/47

V S 150

107

7337.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

AD-93691

G47337 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr-7mo-5days
(e) Length of stay in Baltimore (yrs., mos., or days) 63 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Rief or John Reef

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21-1869

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 8 | 2 | hr. min. |

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Rief or George Reef (D
13. Birthplace Germany

MOTHER
14. Maiden Name Maggie ? (D
15. Birthplace Germany

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 9 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 9 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 23- 1946, at 11 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-18 1945, to 12-23- 1946 and that I last saw h in alive on 12-23- 1946

| Immediate cause of death | Duration |
|---|---|
| Cardiac Failure | |
| Due to Arteriosclerotic Heart Disease | yrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.
Address Balt. City Hosp. Date signed 12/30/46

G47338

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

G47338 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1601 Madison Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Wilbert Joshua Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Negro | married |

6 (b) Name of husband or wife Annie Johnson
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | - | 4 | hr. min. |

9. Birthplace Calvert County, Maryland
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Joshua Johnson
13. Birthplace ?

MOTHER
14. Maiden Name Mary Parren
15. Birthplace ?

16 (a) Informant Annie Johnson
(b) Address 2106 N. Howard

17 (a) Burial (b) Date thereof 1/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Brooks Chapel
Location Calvert Co. Md.

18 (a) Funeral director Ag Halstead
(b) Address 946 Druid Hill Ave.

19 JAN 9 1947 (b) Huntington Williams, MD
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 7th 1947 at 1 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6-47 1947 to 1-7 1947 and that I last saw him alive on 1-7 1947

Immediate cause of death Congestive Heart failure — Duration 24 hrs.

Due to Hypertensive Cardio-Vascular Renal Disease — 8 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James D. Carr M. D.
Address 915 Walker St Date signed 1-7-47

VS 150

47339

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 130

Registered 47339

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1303 Penna ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Penna ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Jamie Davis

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Col | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 8 - 1898

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 48 | 4 5 | | hr. min. |

9. Birthplace Charles Co - Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business —

FATHER
12. Name Frank Easley
13. Birthplace Md

MOTHER
14. Maiden Name Katherine Ann ?
15. Birthplace Md

16 (a) Informant Margaret Jones
(b) Address 1303 Penna ave

17 (a) Burial (b) Date thereof 1 10 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore
18 (a) Funeral director William J. Jackson
(b) Address 916 Pennsylvania ave

19 (a) JAN 9 1947 (b) [illegible] Registrar

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-6 1947 at 9A M

21. I certify that death occurred on the date above stated, that I attended deceased from 12-28 1946 to 1-6 1947
and that I last saw h[illegible] alive on 1-5 1947

Immediate cause of death
(a) Acute dysluchanata
Due to Parenchymatous

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

| Duration |
|---|
| 9 Dys |
| year |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. N. Hatcher M.D.
Address 1 W Pa Ave Date signed 1/7/47

X

G47340 | BALTIMORE CITY HEALTH DEPARTMENT | G47340

# CERTIFICATE OF DEATH

93D

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20A
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 665 W. Fayette (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ANNE SUTTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: m

6 (b) Name of husband or wife: Patrick H

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb 22-1890

8. AGE: Years: 56 55 | Months: 10 | Days: 14 16 | If less than one day: hr. min.

9. Birthplace: N C. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden Name: "
15. Birthplace: "

16 (a) Informant: Mrs. J. P. Bass
(b) Address: Richmond, Va

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/9/47 (month) (day) (year)
(c) Cemetery or crematory: Richmond Va
Location: Richmond Va

18 (a) Funeral director: Williams Bros. Inc
(b) Address: 1217 St. Paul St

JN 9 1947 Date rec'd. Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/8/47 19 8:17 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to PER death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardiovascular Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: John Gilmore M.D. Medical Examiner.
Date signed 1/9/47

X

VS 131

G47341

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 97

G47341 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3813 Reisterstown Road.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3813 Reisterstown Road.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** SARA ELSASSER ROSE.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Jacob L. Rose.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1874.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 11 | | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Levi Elsasser,
13. Birthplace Germany.

MOTHER
14. Maiden Name Caroline Einstein,
15. Birthplace Germany.

16 (a) Informant Mr. Arthur L. Rose,
(b) Address 3813 Reisterstown Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1.10.47. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris Funeral Home
(b) Address 1902 Eutaw Place.

19 (a) JAN 9 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 8th. 1947, at P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1947, to Jan 8 1947, and that I last saw h[illegible] alive on Jan 7 1947.

Immediate cause of death: Myocardial failure — Duration: 6 days
Due to Arteria-sclerosis & Emphysema — 2 yrs
Due to
Other Conditions Contributory pneumonia, Hypo-static — 4 days
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place)
(e) Means of injury
23. Signature J. Frederick Leitz M. D.
Address Temple Garden Apts Date signed 1/9/47

VS 150

X

G47342

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46B

G47342 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2111 Park Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Lina Katz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband ~~or wife~~ Herman W. Katz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17 1874

8. AGE: Years 72 | Months 4 | Days 23 | If less than one day hr. min.

9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation Paper Supplies
11. Industry or business

FATHER 12. Name Benj. Ehrman,
13. Birthplace Germany

MOTHER 14. Maiden Name Adelina Wurtzburger,
15. Birthplace Balto, Md.

16 (a) Informant Mrs. Ansel Ehrman,
(b) Address 2409 Brookfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Hebrew Friendship
Location Baltimore Md.

18 (a) Funeral director David Sonnenborn
(b) Address 202 Eutaw & Lee

19 (a) JAN 9 1947 (Date received by registrar) Hunter Jon Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 9, 1947 at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1946 to Jan 9 1947. and that I last saw her alive on Jan 9 1947

| Immediate cause of death | Duration |
|---|---|
| Generalized carcinoma | |
| Due to Ca Head pancreas & liver | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation Dec. 26, 1946
Major findings of operations: Carcinoma of Stomach Head of Pancreas & liver
of autopsy: Refused to Give

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel D. Gaby, M.D.
Address Sinai Hospital Date signed 1/10/47

VS 150

G47343

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 117a

Registered No. G47343

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3643 Dolfield ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3643 Dolfield Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Samuel Edland

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Sadie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Furniture Finisher
11. Industry or business

FATHER
12. Name Jadak
13. Birthplace Russia

MOTHER
14. Maiden Name Dosha
15. Birthplace Russian

16 (a) Informant Sadie Edland
(b) Address 3643 Dolfield ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-9-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Balto St

19 JAN 9 1947 (Date rec'd by Registrar) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-9- 1947 at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5 1947 to 1/9 1947 and that I last saw him alive on 1/9 1947.

Immediate cause of death
Coronary Occlusion — Duration 4 hrs
Due to
Due to
Other Conditions Gastric Ulcer — Duration 2 yrs
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. J. Bayless
Address 3640 Eutaw Pl Date signed 1/9/47

VS 150

47344

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 171a

Registered No. G47344

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 Park Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Augusta F. Ditty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1870

8. AGE: Years (76) | Months 5 | Days 30 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Teacher -- public schools

11. Industry or business retired - 14 yrs.

12. Name C. Irving Ditty

13. Birthplace A. A. Co. Md

14. Maiden Name Sophia Leupold

15. Birthplace Balto - Md

16 (a) Informant Sophia F. Decker

(b) Address 230 N. Lamdale Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jany 11 '47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location 3801 Frederick Ave

18 (a) Funeral director John O. Mitchell Home

(b) Address 1900 Eutaw Place

19 (a) JAN 9 1947 Registered by ... (b) Huntington Williams M.D.

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## MEDICAL CERTIFICATION

20. DATE OF DEATH January 8, 1947 at 2 75 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull Intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-8-47 at 12 Noon 14/1 M.
(b) Where did injury occur? London Park Cemetery
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian Struck by Street Car

23. Signature Howard J. Tweedie M.D. Medical Examiner.
Date signed 1-9-47

G47345 ✓ G47345

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 55E

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4 N. Athol Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 N. Athol Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Leon J. de Bullet

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Laura E. Whitely
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 22, 1877

8. AGE: Years 69 | Months 9 | Days 18 | If less than one day hr. min.

9. Birthplace S. C.
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Farcis A. J. de Bullet
13. Birthplace Cuba

MOTHER
14. Maiden Name Carlota Traub
15. Birthplace Cuba

16 (a) Informant Laura E. de Bullet
(b) Address 4 N. Athol Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/11/47 (month) (day) (year)
(c) Cemetery Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Waterhouse & Sons Inc.
(b) Address 1900 Eutaw Place

19 (a) JAN 9 1947 (Date received by registrar) Huntington Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9 1947; at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12 1946 to 1-8 1947 and that I last saw him alive on Jan. 8 1947.

Immediate cause of death: Cerebral Thrombosis. — Duration 1 da.

Due to Arteriosclerosis Melanoma — 2 mo

Due to Malignancy of Lip — 1 yr.

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nelson K. Gallagher M.D.
M. D.
Address 6209 Frederick Ave. Date signed 1-9-47

VS 150

G47346

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47346 Registered No. 1900

1. PLACE OF DEATH: BALTIMORE CITY
(a) Baltimore City, Maryland GETZ'S RESTAURANT
(b) Street address Basement room
(c) Hospital or institution: FREDERICK AVENUE
Stagnes Hospt
(statement by Dr. Maldeis 1-9-47)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
Dead on arrival
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town: 5715 Main St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Elkridge
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Calvin Peary.

3 (b) If veteran, name war none | 3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Sallie [illegible] Peary
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Feb 20 1870

8. AGE: Years 76 | Months 10 | Days 3 | If less than one day hr. min.

9. Birthplace Dantonsville, Md
(Town, county, and state)

10. Usual Occupation Gen. Dairy agent, [illegible]
11. Industry or business Retired

FATHER
12. Name Charles Milton Peary
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Klein
15. Birthplace Virginia

16 (a) Informant Mrs W.N. Brown
(b) Address 5715 Main St, Elkridge Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 26/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto, Md.

18 (a) Funeral director Wm. Tucker Sons
(b) Address Light & Pennsylvania Aves

19 (a) Dec 24 1946 (Date rec'd by registrar) Emile C. Bird Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1946 at 1.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1939 to Dec 23 1946 and that I last saw him alive on Dec 22 1946

Immediate cause of death: Acute Coronary Occlusion — Duration 2 hrs
Due to: Chr Myocarditis — 8 yrs
Due to: Arterial Hypertension — 24 yrs
Other Conditions: Senility
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W.B. Greenbaugh M. D.
Address 5709 Main St Elkridge Md Date signed 12/23/46

VS 150

47347 BCH 965605

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 179X

G47347 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto Co. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto.
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 80 Lynch Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** John Macek

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M. | W. | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/19/46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 1 | 20 | hr. min. |

9. Birthplace 12/19/46 Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Adam Macek

13. Birthplace W Va.

MOTHER 14. Maiden Name Mary Penny

15. Birthplace Balto Md

16 (a) Informant Adam Macek.

(b) Address Lynch Rd.

17 (a) Burial (b) Date thereof 1-10-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Saint Hedwig's Cem.

Location Lynch Rd

18 (a) Funeral director James J Brudzinski

(b) Address 1907 Eastern Ave R 9

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** January 8, 1947, at 9.45 P. M

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Boric Acid Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.

Date signed 1/10/47

VS 151

X 121

17348

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

939

647348 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 714 E 36th
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-3
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 714 E 36th (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ora Lee Rohr

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Wilhemina L Rohr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10 1868

8. AGE: Years 78 | Months 4 | Days 29 | If less than one day hr. min.

9. Birthplace Ga (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Long
13. Birthplace Ga

MOTHER
14. Maiden Name Sarah Lynn Long
15. Birthplace Ga

16 (a) Informant Ernest L Rohr
(b) Address 115 Judy St Covington Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/11/47 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Jersey Md

18 (a) Funeral director Wilhemina Coh Inc
(b) Address 1219 Ft Ave

19 JAN 10 1947 (b) Washington Millington Md Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to 1947. and that I last saw h[illegible] alive on Jan 8 1947

Immediate cause of death: Heart Decompensation — Duration

Due to: Hypertensive C-V Disease

Due to:

Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin G Hansman M. D.
Address 4037 Edmondson Ave. Date signed 1/9/47

VS 150

7349

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. C47349

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1111 McAleer Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 McAleer Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F. Browning Sr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: Annie A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27th 1867

8. AGE: Years 74 | Months 6 | Days 11 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name William Browning
13. Birthplace Md

MOTHER
14. Maiden Name Margaret E.
15. Birthplace Md

16 (a) Informant Mrs. Anna Southard
(b) Address Fullerton Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/11/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) JAN 10 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8th 1947 at 3.30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 1 1947 to Jan 8 1947, and that I last saw him alive on Jan 8 1947

Immediate cause of death

Due to Hypertensive Cardiac

Due to Jaundice Verified

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration: 7 days

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred Reynolds Sr

Address 610 Butler Rd Date signed 1-9-47

VS 150

7350

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G47350
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1450 Decimus St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Casper Ries Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | married |

6 (b) Name of ~~husband~~ or wife Lula Ries

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-9-1892

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 | — | — | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Police Manager
11. Industry or business Self

FATHER
12. Name Casper Ries
13. Birthplace Md

MOTHER
14. Maiden Name Mary Bakken
15. Birthplace Balto Md

16 (a) Informant Lula Ries
(b) Address same

17 (a) Burial (b) Date thereof 1/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location a.a. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

JAN 10 1947 (b) Huntington Williams, M.D.
(Date rec'd by Registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 9 1947 at 12.07 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-9 1947 to 1-9 1947 and that I last saw him alive on 1-9 1947.

| Immediate cause of death | Duration |
|---|---|
| Myocardial Failure | |
| Due to Arteriosclerotic C-V disease | 10 20 to 12 07 P.M. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Myocardial Dilatation Coronary sclerosis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Edward H. Southwick
Address Franklin Sq. Hosp. Date signed 1/9/47

7351

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

74a

Registered No. G47351

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Pa. (b) County
(c) City or town Philadelphia
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3342 Chippendale Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Nolen, Kathryn Louise

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced: |
|---|---|---|
| F | W | Widow |

6 (b) Name of husband or wife Walter Nolen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1899

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 47 | 5 | 26 | hr. min. |

9. Birthplace Phila, Pa.
(Town, county, and state)
10. Usual Occupation Stenographer
11. Industry or business US PHS

FATHER
12. Name William de Haven
13. Birthplace Phila, Pa.

MOTHER
14. Maiden Name Mary Corcoran
15. Birthplace Pennsylvania

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Removal (b) Date thereof 1/10/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Sepulchre
Location Phila. Pa.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St.

19 JAN 10 1947 (b) Huntington Williams M.D.
(Date received by Registrar) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 9 1947, at 7:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30 1946, to Jan. 9 1947, and that I last saw h[illegible] alive on Jan. 9 1947.

| Immediate cause of death | Duration |
|---|---|
| Chronic Myelogenous Leukemia | 2 Yrs. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Pathology
of autopsy: Splenomegaly-Infarcts Hepatomegaly

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Eugene J. Goldbeck M.D.
Address US Marine Hospital Date signed 1/9/47

7352

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

G47352 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address D.O.A.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 902 Sarah Ann St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Lomax

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/91

8. AGE: Years 56 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Out of work

11. Industry or business

FATHER
12. Name James Lomax
13. Birthplace Va

MOTHER
14. Maiden Name Mary Thomas
15. Birthplace Va

16 (a) Informant Charlotte Douglas
(b) Address 1012 W Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director David B Brown Son
(b) Address 1018 W Mount Royal Ave

JAN 10 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/4 1947, at 6:20 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic - Cardio-Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Pasbrickel M.D.
Medical Examiner.
Date signed 1/5/47

VS 151

X

7353

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 107

G47353
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 732 Warner Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State 732 (b) County
(c) City or town 932 Warner St
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Sophia Kell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 79 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Joan Janus Johnson
13. Birthplace Md

MOTHER
14. Maiden Name Mary Jones
15. Birthplace Md

16 (a) Informant Brother / Farrel
(b) Address 6/8 6 Monty omery St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/47 (month) (day) (year)
(c) Cemetery or crematory Calvert County Md
Location ✓

18 (a) Funeral director Isaac L Brown Son
(b) Address 1080 W Monty Omery St

JAN 10 1947 (Date rec'd by Registrar) (b) Huntington Williams MD

VS 130

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jany 6 1947 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27/46 to 1/6/ 1947, and that I last saw h[illegible] alive on 1/6/47 1947.

Immediate cause of death

(a) Broncho Pneumonia — Duration

Due to

Due to

Other Conditions Arteriosclerosis Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature W. P. Howells M. D.
Address 601 N. Arrow St Date signed 1/9/47

X

254

106783

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13

G47354
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 Years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1529 E. Fayette Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Leroy Carmichael or Leroy Carmicheal

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | Col. | Married |

6 (b) Name of husband or wife Louise Stinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1920

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 26 | 7 | 1 | hr. min. |

9. Birthplace Winston Salem, North Carolina
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Jaybee Carmichael or Carmicheal
13. Birthplace North Carolina

MOTHER
14. Maiden Name Dora ? Carmicheal or Carmichael
15. Birthplace North Carolina

16 (a) Informant Baltimore City Hospital Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof Jan. 11, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1010 Beatty ave

JAN 10 1947
(Date received by Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 8 1947, at 11:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from December 11 1946 to Jan. 8 1947, and that I last saw him alive on Jan. 8 1947.

Immediate cause of death Pulmonary Tuberculosis, Far Advanced — Duration 4 yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Refused

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Hunt M. D.
Address Balt. City Hosp. Date signed 1-9-47

V S 150

47355

NCD 106762

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1176

Registered No. C47355

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1225 Linden Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ~~Frank Burnham~~ Frank Burnham

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Widowed |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 4 | 7 | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business

FATHER
12. Name Thomas J. Burham or Burnham (d)
13. Birthplace England

MOTHER
14. Maiden Name Mollie Pettitt
15. Birthplace Virginia

16 (a) Informant Baltimore City Hospital Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 11th 1947 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Frederick Road

18 (a) Funeral director Leo S. Brooke
(b) Address 1701-03 N. Patterson Park ave

19 JAN 10 1947 (Date received by Registrar) (b) Huntington Williams, M.D.

V S 190

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 1947, 10:10PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 10 1946 to Jan. 8 1947, and that I last saw him alive on Jan. 8 1947.

| Immediate cause of death | Duration |
|---|---|
| Generalized Peritonitis | 3 days |
| Due to Rupture Gallbladder abdominal | |
| Due to ~~mucous~~ — duodenum | |
| Other Conditions Duodenal ulcer | |

(Include pregnancy within 3 months of death)
Date of operation 11/3/47 & 11/7/47
Major findings of operation: Duodenal ulcer Generalized peritonitis
of autopsy: P.O. rupture duodenum

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature R. S. Gibbs
Address Balti. City Hospitals Date signed 1/9/47

047356

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 186a

047356 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution:
Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10d.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3433 E. Balto. St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Marie C. Smith

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | 218-07-5111 |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Wm. H. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1904

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 42 | 6 | 0 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Waitress
11. Industry or business Crown, Cork & Seal Co.

FATHER
12. Name Frank Johnson
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sophia Krame
15. Birthplace Balto. Md.

16 (a) Informant Mr. William H. Smith, Husband
(b) Address 3433 E. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/13/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JAN 10 1947 (By) Huntington Williams, M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 9 1947 at 7:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-30 1946, to 1-9 1947, and that I last saw h[illegible] alive on 1-9 1947

Immediate cause of death [illegible] Duration
Massive Pulmonary Embolism 1½ hrs.
Due to Phlebo-Thrombosis, prob. Pt. Leg 10 days
Due to
Other Conditions Tract. of Upper ½ of Pt. Femur 10 d.
(Include pregnancy within 3 months of death)
Date of operation 1-2-47.
Major findings of operation Fract. (Open Reduct.)
of autopsy: Occlusion of Pulm. Artery

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 25/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence December 30 '46 at 6 P M
(c) Where did injury occur? 3433 E. Balto. St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? no
(Specify type of place)
(e) Means of injury Jumped or fell to floor
23. Signature William D. Tenley, Jr. M.D.
Address Mercy Hosp. Date signed 1-9-47

Howard J. Mackie, M.D.

7357

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. 047357

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 524 N. Charles St., then to
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 407 Kensington Road
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

**3 (a) FULL NAME** Clarence Beale Pitt

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| 1st. World War | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M. | W | M. |

6 (b) Name of husband or wife Mrs. Dorothy T. Pitt
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Oct 20, 1892

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 | 3 | 19 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Mnf.
11. Industry or business Bakers Supplies

FATHER
12. Name Clarence M. Pitt
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Elma Davis
15. Birthplace Richmond Va.

16 (a) Informant W. B. Pitt.
(b) Address 210 Edgevale
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 11-47 (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md
18 (a) Funeral director Wm. Rieman Sons
(b) Address Northern Ave.

JAN 10 1947 (Date rec'd by Registrar) Huntington Williams, M.D.

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Jan 9 1947, at 2 P. M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2 years 19 to date 19, and that I last saw him alive on Jan 9 1947.

| Immediate cause of death | Duration |
|---|---|
| Myocardial Infarction | |
| Due to Coronary Thrombosis | |
| Due to Immediate | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature Carroll Packard M. D.
Address 92 N. Charles St Date signed 9 Jan 47.

VS 150

7358

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47358 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 N. Peare St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Joseph H Varnelis

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Widowed |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 9 | 20 | hr. min. |

9. Birthplace Lithuania
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business Clothing

FATHER 12. Name Anthony Varnelis

FATHER 13. Birthplace Lithuania

MOTHER 14. Maiden Name Eva Sadauskas

MOTHER 15. Birthplace Lithuania

16 (a) Informant Victor J. Varnelis

(b) Address 934 Carsdale, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/11/47 (month) (day) (year)

(c) Cemetery or crematory Meadow Ridge

Location Jessup, Md.

18 (a) Funeral director John J. Cowan & Son

(b) Address 901-903 Hollins St.

JAN 10 1947 (Date rec'd by registrar) Hamilton Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-9- 1947, at 12:40 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Acute Pulmonary Edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Weeks M.D.
Medical Examiner.

Date signed 1-9-47

VS 151

7359

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. 47359

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1718 W Lombard St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1718 W Lombard (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes M Deckhoff

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Thames M
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23 1906

8. AGE: Years 41 | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace Balt Md (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Aloysius Prendale
13. Birthplace Md

MOTHER
14. Maiden Name Hattie M Downey
15. Birthplace Md

16 (a) Informant Thames Deckhoff
(b) Address Arnold Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-11-47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director George A Foley
(b) Address Fulton & Fayette

JAN 10 1947 Huntington Williams M.D. (Registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 1947, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1946 to Jan 7 1947 and that I last saw h[illegible] alive on Jan 6 1947.

Immediate cause of death Cardiac failure — Duration

Due to Chronic Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Bennett M. D.
Address 1724 W Lombard St Date signed 1/9/47

47360

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. C47360

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3002 Hudson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3002 Hudson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William J Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 9. 1870

8. AGE: Years 76 | Months 2 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Labour

11. Industry or business

FATHER
12. Name George W Thomas
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth J Stewart
15. Birthplace Md

16 (a) Informant Mrs Thompson
(b) Address 3002 Hudson St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Jan 11-47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn Md

18 (a) Funeral director William Cook Inc
(b) Address 617 St Paul St

JAN 10 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Jan 8 1947 at 10:30 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2-15 1944 to 1-8-1947 and that I last saw h[illegible] alive on 1-8-1947

Immediate cause of death Chr. Myocarditis — Duration 3 yrs ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23. Signature** W J Davidson M. D.

Address 3218 Eastern Ave Date signed 1-9-47

47361

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46F

Registered CA7361

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4300 Parkmont Avenue
(c) Hospital or institution:

46

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4300 Parkmont Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARGARET JUNKER

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Divorced |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26, 1863

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 9 | 13 | hr. min. |

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Hansel
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Krummelbein
15. Birthplace Germany

16 (a) Informant Mrs. Margaret Gossmann
(b) Address 4300 Parkmont Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/10/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

JAN 10 1947
VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 8 1947, at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29 1946 to Jan. 8 1947. and that I last saw her alive on Jan. 6 1947.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma, gall bladder & liver | 14 mos. +. |
| Due to | |
| Due to | |
| Other Conditions The mitral regurgitation (Include pregnancy within 3 months of death) | 5 yrs. + |

Date of operation none
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. M. Bacon M. D.
Address 2810 Taylor Ave. Date signed 1/8/47

X

G47362

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1110 B

G47362 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1067 W. Lexington Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1067 W. Lexington Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Louise Culver

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | Married |

6 (b) Name of husband or wife Daniel Culver
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Oct. 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 3 | | hr. min. |

9. Birthplace Anne Arundel County, Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Nick Smith
13. Birthplace Anne Arundel County, Md.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Ray Culver
(b) Address 1067 W. Lexington Street

17 (a) Burial (b) Date thereof Jan. 10 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St.

19 JAN 10 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 3

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 7, 1947, at 5:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 5 1947, to January 7, 1947, and that I last saw h.e.r. alive on January 6, 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardiac Failure | Several hrs. |
| Due to Pleurisy | 5 days. |
| Due to Senility | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard A. Hunt M. D.
Address 1107 W. Mulberry St. Date signed 1-7-47

X

G47363

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

Registered No. G47363

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1208 N. Amity St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 N. Amity St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Alice Riley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Thomas Riley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1902

8. AGE: Years: 44 | Months: 8 | Days: 4 | If less than one day: hr. min.

9. Birthplace Calvert Co Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Laurence
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Alice
15. Birthplace Md.

16 (a) Informant Thomas Riley
(b) Address 120 N. Amity St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 10, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Wilfong
(b) Address 322 N. Schroeder St.

19 (Signature of registrar)
JAN 10 1947
Registrar for Baltimore, Md.

V S 190

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/6/47 19 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/6/47 to 1/6/47 and that I last saw h— alive on 1/5/47

Immediate cause of death: Diabetes Mellitus

Due to: Lobar pneumonia

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Lee Riley M. D.
Address 924 Park Ave. Date signed 1/7/47

X

G47364

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1108

Registered No. G47364

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2349 N. Carey St
(c) Hospital or institution:
19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2349 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Maria Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John Cooper

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9 1894

8. AGE: Years 52 | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace Laurel Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Burley
13. Birthplace Va.

MOTHER
14. Maiden Name Rebecca Clark
15. Birthplace Md.

16 (a) Informant Virgie Cooper
(b) Address 2349 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 12 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Lion Cem
Location Laurel Md.

18 (a) Funeral director Wm. Wade R. Williams
(b) Address 322 N. Schroeder St.

19 JAN 10 1947 (b) Huntington Williams M.D.
(Date received by registrar)

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan. 7 1947, at 10:50 PM

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan. 3 1947 to Jan. 7 1947 and that I last saw h. alive on Jan. 6 1947.

Immediate cause of death: Lobar Pneumonia — Duration: 4 days

Due to

Due to

Other Conditions: Acute syphilitic cystitis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature H. Walter Pennington M.D.
Address 201 N. Carey St. Date signed 1/10/47

V S 150

17365

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G47365

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3713 Nortonia Road
(c) Hospital or institution:
15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3713 Nortonia Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Isaac McCarty Long

3 (b) If veteran, name war

3 (c) Social Security Account No. No

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widower |

6 (b) Name of ~~XXXXXX~~ wife Sarah E. Long
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 27,1851

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 95 | 9 | 13 | hr. min. |

9. Birthplace Keyser, W. Va.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Cornelius Long
13. Birthplace W. Va.

MOTHER
14. Maiden Name Elizabeth McCarty
15. Birthplace W. Va.

16 (a) Informant Mrs. C. Howard Scherer
(b) Address 3713 Nortonia Road

17 (a) Burial (b) Date thereof 1-12-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Queenspoint
Location Keyser, W. Va.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) JAN 10 1947 Registrar Williams M.D.

**MEDICAL CERTIFICATION** A.

20. DATE OF DEATH January 9, 1947, at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1, 1946 to Jan. 9 1947. and that I last saw him alive on Jan. 7, 1947.

| | Duration |
|---|---|
| Immediate cause of death Acute dilitation of heart | 2 days |
| Due to Myocarditis about | 1 year |
| Due to Arteriosclerosis | ? |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter Dunbar M. D.
Address 220 Harrison Blvd Date signed 1/10/47

VS 190

G47366

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G47366

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 6909 Harford Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6909 Harford Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Daisy Lillie Godmon

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | White | widow |

6 (b) Name of husband or wife William F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11-1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 3 | 29?8 | hr. min. |

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mrs. Thelma De Vean
(b) Address 6909 Harford Road

17 (a) Burial (b) Date thereof 1-11-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 JAN 10 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-9- 1947, at 3-30 A.M

21. I certify that I took charge of the remains described above, held an Susp & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 1-9-47

G47367 BCH 866564

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1108

Registered No. G47367

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Lanvale & Linden Ave
(c) Hospital or institution: West Baltimore Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2542 Roth Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Dennis Reuty

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-28-1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 12 | hr. min. |

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name George Reuty
13. Birthplace Pa.

MOTHER
14. Maiden Name Josephine Palmeri
15. Birthplace Md.

16 (a) Informant Mrs. Josephine Reuty
(b) Address 2542 Roth Street.

17 (a) Burial (b) Date thereof 1-10-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

JAN 10 1947 (b) Huntingtown Williamsport, Md.
(Date rec'd by registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 9 January 19 47 at 1:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9 Jan 19 47 to 9 Jan 19 47 and that I last saw him alive on 9 Jan 19 47

Immediate cause of death Cardio respiratory failure

Due to Toxic Effects Edema Peripheral Vascular failure

Due to Bilateral pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lester A. Pratt Jr. M.D.

Address [illegible] Date signed 1/9/47

EDGER

47368

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 111c

Registered No. G47368

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1615 Park Ave.
(c) Hospital or institution: 14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anna Hall Edger

3 (b) If veteran, name war
3 (c) Social Security Account No. *

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Geo. W. Edger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jany. 30.1863

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 11 | 8 9 | hr. min. |

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Owen D. Hall
13. Birthplace

MOTHER
14. Maiden Name Annie E. Blizzard
15. Birthplace

16 (a) Informant Miss Haldeman
(b) Address 1615 Park Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Jany 11.194* (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell Funeral Home
(b) Address 1900 Eutaw Place

JAN 10 1947 (Date rec'd by registrar) (b) Huntington Ave. Millington Md.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jany 8.1947 19 at 9.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Jan 9 1947 and that I last saw h alive on 19

Immediate cause of death: Hypostatic Pneumonia — Duration 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. R. Johnson M. D.
Address Medical Arts Bldg. Date signed

VS 150

47369
AB-105471

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G47369

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos- 15days
(e) Length of stay in Baltimore (yrs., mos., or days) 67 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 200 N. Rose St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ketherine Schriefer

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widow |

6 (b) Name of husband or wife Frank (D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18- 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 10 | 19 | hr. min. |

9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Bodine (D
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Smith (D
15. Birthplace Germany

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 11/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location O'Donnell S t.

18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.

19 (a) (Date rec'd by reg.) JAN 10 1947 (b) Burial for Williams, M.

**MEDICAL CERTIFICATION** PM

20. DATE OF DEATH Jan. 7- 1947, at 1145M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-28- 1946, to 1-7 1947, and that I last saw h er alive on 1-7 1947.

| Immediate cause of death | Duration |
|---|---|
| Diabetic ar- teriosclerotic Gangrene of left leg | |
| Due to Arteriosclerotic Cardiovascular Disease & | |
| Due to Diabetes mellitus | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 12-31-46
Major findings of operation: Above
of autopsy: Above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice M. Levy M. D.
Address Baltimore City Hosp. Date signed 1-7-47

G47370
507546

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G47370

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. Wesley Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gabie Butcher

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Black | married |

6 (b) Name of husband or wife Alice.
6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) 11-30-89

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 1 | 7 | hr. min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Chef.
11. Industry or business

FATHER
12. Name Josh Butcher
13. Birthplace Md

MOTHER
14. Maiden Name Bowie
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 1-13-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Baltimore Co., Md.
18 (a) Funeral director Mrs. Frances A. Hematy
(b) Address 518 W. Biddle St.
19 (a) Filed JAN 10 1947 Huntington Williams, Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7 1947 at 8.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 6 1947 to Jan 7 1947 and that I last saw him alive on Jan 7 1947.

Immediate cause of death Obstruction of common bile duct due to calculus, Cholecystitis acute, Cholangitis

Duration ? 5 wks.

Due to

Due to

Other Conditions Anemia, hypertension, Myocardial hyper trophy, Lft

? 1 yr.

(Include pregnancy within 3 months of death)
Date of operation Jan 7. 47
Major findings of operation: As Above
of autopsy: As Above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Eugene Meyer III M. D.
Address Johns Hopkins Date signed Jan 8 47

VS 150

G47371

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

Registered No. G47371

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1832 W Baltimore st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No 1832 W Baltimore
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Grace R. Dougherty

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26 1870

8. AGE: Years 76 | Months 3 | Days 14 | If less than one day hr. min.

9. Birthplace Balt Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thos B. Dougherty
13. Birthplace Md

MOTHER
14. Maiden Name Annie E. Sheilds
15. Birthplace Ireland

16 (a) Informant Jos E. Dougherty
(b) Address 1902 W Lanvale

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-46 (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Lopez & Farley
(b) Address Fulton & Fayette

19 1947 JAN 10 (Date filed by Registrar) (b) Williamson Md

VS 130

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 - 1947, at 6.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 28 1946, to Jan 8 1947, and that I last saw h[illegible] alive on Jan 8 1947.

| | Duration |
|---|---|
| Immediate cause of death: Cerebral Hemorrhage | 3 wks |
| Due to: Arteriosclerosis | 5 yrs |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isaac C. Dickson M. D.
Address 3035 N. North ave Date signed Jan 10-47

X

47372

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 30E

Registered No. G47372

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1280 BATTERY AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1280 BATTARY AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE. K. MILLER.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: FEM

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: GUSTAVE MILLER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): FEB 10 1892

8. AGE: Years 54 | Months 10 | Days 30 29 | If less than one day ____ hr. ____ min.

9. Birthplace: BALTIMORE MD
(Town, county, and state)

10. Usual Occupation: HOUSE WIFE.

11. Industry or business: — —

FATHER
12. Name: BENJAMIN HETTAU
13. Birthplace: BALTIMORE MD

MOTHER
14. Maiden Name: LENA SCHADEL
15. Birthplace: BALTIMORE MD

16 (a) Informant: GUSTAVE MILLER
(b) Address: 1280 BATTERY. AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: JAN - 13 47 (month) (day) (year)
(c) Cemetery or crematory: HOLY CROSS
Location: A A. Co.

18 (a) Funeral director: Bernard C Harle
(b) Address: 121 E West St

19 (a) (Date received by Registrar) (b) Washington Williamsport, Md.

JAN 10 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 9 1947, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/13 1946 to Jan. 3 1947, and that I last saw h alive on Jan 5 1947.

Immediate cause of death: Staphylococcic Cardiovascular Disease

Due to: Sepsis

Due to:

Other Conditions: Hypertension

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

| Duration |
|---|
| not known |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: W. D. Allison M. D.

Address: 107 E. West St Date signed: 1/10/47

X

7373

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. G47373

CWK-107366

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 120 S. Exeter Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nicola Ruscitti

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Marital status unknown |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 5 | 24 | hr. min. |

9. Birthplace xxxxxxxx Italy
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name xxxxxxx Giovanni Ruscitti
13. Birthplace Italy

MOTHER
14. Maiden Name xxxxxxxx Gaetana
15. Birthplace Italy

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof Jan 13 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd. Balt. Md.

18 (a) Funeral director Israel Dellatore
(b) Address 52 N. Morley St.

19 JAN 10 1947 Huntington Williams M.D.
(Date rec'd by registrar)

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH Jan. 9 1947, at 2:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 6 1947, to Jan. 9 1947, and that I last saw him alive on Jan. 9 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 4 days |
| Due to Perforation of Diverticulum of Ileum | 4 days |
| Due to Arteriosclerosis | yrs |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes Tentative

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.
Address Balt. City Hosp. Date signed 1/10/47

V S 150

G47374

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 95c

Registered No. G47374

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3121 Clearview Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3121 Clearview Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Carrie Lee Harvey

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Late James Murray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 3 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 5 | 6 | hr. min. |

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Rubin Reitenauer
13. Birthplace Pa

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Rachael E Bolton
(b) Address 3121 Clearview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 11, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director Henry H Withe
(b) Address 4101 Edmondson Ave

19 (a) (Date received) JAN 10 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 9 1947, at 1 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1946 to Jan 9 1947 and that I last saw h. alive on Jan 9 1947

Immediate cause of death: Cardiac decompensation (Arteriosclerosis) — Duration: Jan 9 1947

Due to:

Due to:

Other Conditions Parkinson's disease — Duration: about 5 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas B. Green M.D.
Address 3009 Eutaw ave Date signed 1/9/47
Baltimore 14 Maryland.

VS 190

G47375

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46F

Registered No. G47375

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1421 Hollins ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1421 Hollins ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lola Valeria Clay

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 9 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 11 | 29 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Wm Covington Clay
13. Birthplace Md

MOTHER
14. Maiden Name Emma Spriggs
15. Birthplace Md

16 (a) Informant Mrs Elizabeth Hutchens
(b) Address 1421 Hollins ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 11 1949 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3501 Frederick Ave

18 (a) Funeral director Harry W Witzke
(b) Address 4101 Edmondson Ave

19 (a) JAN 10 1947 (Registrar's signature) Huntington Williams, M.D. Address 134 W Lombard St. Date signed 1/9/47

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 8 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 23 1941, to Jan 6 1947, and that I last saw her alive on Jan 6 1947

| Immediate cause of death | Duration |
|---|---|
| Carcinoma Liver | 7 |
| Due to | |
| Due to | |
| Other Conditions Arteriosclerosis | 7 |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation
of autopsy —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature Carl P Rostberg M. D.
Address 134 W Lombard St. Date signed 1/9/47

VS 150

G47376

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

877

G47376 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 22 S. Athol Ave.
(c) Hospital or institution: General German Aged Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. Athol ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lucy Zander

3 (b) If veteran, name war —
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | W. | Single |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1859

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 88 | | 6 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Frederick Zander
13. Birthplace Germany

MOTHER
14. Maiden Name Minna Zander
15. Birthplace Germany

16 (a) Informant Mrs. J. Geo. Walz.
(b) Address 22 S. Athol Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 11/47 (month) (day) (year)
(c) Cemetery or crematory Westlow
Location Edmondson Ave. & Longwood St.

18 (a) Funeral director Harry A. Nichols
(b) Address 4101 E. Monument ave

JAN 10 1947 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9, 1947, at 3.30 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 20/46, to Jan. 9/47, and that I last saw her alive on Jan. 2/47

| Immediate cause of death | Duration |
|---|---|
| Cardiac Fibrosis. | Unknown. |
| Due to Multiple Sclerosis. | Unknown. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Theodore Chandler M. D.
Address 930 Hanover Date signed Jan 9 1947.

VS 150

17837 (2)

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93

Registered No. G47377

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1931 Edmonson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ERNEST SCHUMANN

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Widowed |

6 (b) Name of husband or wife late Kathryn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 4 | 7 | hr. min. |

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Charles Fiss & Son

FATHER
12. Name Schumann
13. Birthplace Germany

MOTHER
14. Maiden Name Lena Fite
15. Birthplace Germany

16 (a) Informant Mrs Lee Flynn
(b) Address 510 S. Brunswick St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 11 1947 (month) (day) (year)
(c) Cemetery or crematory Westminster
Location Davey, Md.

18 (a) Funeral director Harry H Withe
(b) Address 4101 Edmondson ave

19 JAN 10 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/8/47 19 at 7:00 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davey M.D. Medical Examiner.
Date signed 1/8/47

X

G47378

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131B

Registered No. G47378

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Lisle Sisters of the Poor
(c) Hospital or institution: 1200 Valley Street Baltimore 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 N. Lafayette Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** Bessie Carey (Mary E Carey)

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | white | single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | | | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Carey
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah Curran
15. Birthplace Ireland

16 (a) Informant Lisle Sisters of the Poor
(b) Address 1200 Valley Street city

17 (a) Burial (b) Date thereof 1-11-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Sec Superior Lot

18 (a) Funeral director Bill Bahen Home
(b) Address 1318 Light St

19 (a) JAN 10 1947 Huntington Williams, M.D.
(Signature of Registrar)

VS 3

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1947, at 1:28 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1946, to Jan 9 1947, and that I last saw her alive on Jan 8 1947.

Immediate cause of death Edema Lungs — Duration 1 day

Due to Chronic myocarditis — 3 yrs

Due to

Other Conditions Chronic nephritis — 2 yrs

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E. North Ave Date signed 1/9/47

93D

7379

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G47379

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1633 Madison
(c) Hospital or institution: 14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1633 Madison
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** HUNTER PYLES

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | | | hr. min. |

9. Birthplace (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name John Marshall
13. Birthplace Louisiana S.C.

MOTHER
14. Maiden Name Nancie Hunter
15. Birthplace Louisiana S.C.

16 (a) Informant Louise Howard
(b) Address 1633 Madison Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 1-11-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Balto. Md.

18 (a) Funeral director Archibald C. Gaddis
(b) Address 2101 McCulloh St.

JAN 10 1947 (b) Huntington Williams, M.D.
(Date rec'd by local reg.)

JAN 11 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/8/47 19 at 7:10 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John Evans M.D.
Medical Examiner.
Date signed 1/9/47

X

47380

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. G47380

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4441 Newport Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give county)
(d) Street No. 1233 Dellwood Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Elizabeth Prigg

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-03-8067

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7-1900

8. AGE: Years 46 | Months 11 | Days 7 | If less than one day hr. ___ min. ___

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Deveraux D. Prigg
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma B. Snowden
15. Birthplace Maryland

16 (a) Informant Mrs. Emma B. Galloway
(b) Address 1233 Dellwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 13-1947 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Hampden
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) JAN 11 1947 Huntington Williams, M.D.
(Signature of registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 9 1947, at 8:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage — Spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Kelly M.D. Medical Examiner.
Date signed Jan 9, 1947

VS 151

G47381

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G47381

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd. & Guilford Ave.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) 61

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4722 York Rd.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Clarence W. Armstrong

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-9669

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Mrs. Clarence W. Armstrong
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 3 | 13 11 | hr. min. |

9. Birthplace Baltimore City, Md.
(Town, county, and state)
10. Usual Occupation Laundry office worker
11. Industry or business Laundry

FATHER
12. Name James Armstrong
13. Birthplace Maryland

MOTHER
14. Maiden Name Harriet Winchester
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address 33rd & Guilford Ave.

17 (a) Burial (b) Date thereof 1/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location City

18 (a) Funeral director WIEDEFELD AND SON
(b) Address Greenmount Ave & 22nd St.

19 JAN 11 1947 (b) Huntington Williams M.D.
Date rec'd by Registrar Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 9, 1947, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 18, 1946 to Jan. 9, 1947 and that I last saw him alive on Jan. 8, 1947

| Immediate cause of death | Duration |
|---|---|
| Congestive heart failure | 3 mos. |
| Due to Hypertensive Cardiovascular disease + myocardial infarction | 3 yrs. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Post. Myocardial Infarction.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Crawford N. Fridefeldt, Jr. M.D.
Address Union Memorial Hosp. Date signed 1-9-47

VS 150

G47382

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

54 B

Registered No. G47382

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Mtland & Greene Sts.
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Arbutus
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5231 Arbutus Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F. Reimer (Charles F. Reimer)

3 (b) If veteran, name war: World #1

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Helen A. Reimer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1883

8. AGE: Years 63 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Chief Rate Clerk

11. Industry or business P. R. R.

FATHER
12. Name Frank Reimer
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Regina Reuter
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Helen A. Reimer
(b) Address 5321 Arbutus Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/13/47 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem.
Location Howard Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JAN 11 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/10 1947 at 2.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/17 1946 to 1/10 1947 and that I last saw h[illegible] alive on 1/10 1947.

Immediate cause of death: Pneumonia, Lobar
Antecedent causes: Morbid conditions, if any, giving rise to the immediate cause, stating the underlying cause last.
Due to: Cerebral Hemorrhage

Duration: 2 hrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Laboratory Accuracy

**PHYSICIAN**
Underline the cause to which death should be charged; state-ments.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph L. Fisher, M.D.
Address 5 Reisterstown Rd. Date signed 1/10/47

G47383

AB-107281

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 54a

Registered No. G47383

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days
(e) Length of stay in Baltimore (yrs., mos., or days) 23yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 802 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Richard McNair

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | Married |

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6- 1909

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 37 | 7 | 2 | hr. min. |

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John McNair (D
13. Birthplace N. C.

MOTHER
14. Maiden Name Pearl White
15. Birthplace Va.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 11, 1947 (Month) (Day) (Year)
(c) Cemetery or crematory Druid Hill Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Hallard
(b) Address 1651 Druid Hill Ave.

19 (c) JAN 11 1947 (Date rec'd by registrar) Huntington Williams, M.D.

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8 19 47, at 2.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3 1947, to 1-8 1947, and that I last saw him alive on 1-8 19 47

Immediate cause of death: Glioblastoma — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1/7/47

Major findings of operation: Glioblastoma

of autopsy: Glioblastoma

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. Gibbon M. D.
Address Baltimore City Hosp. Date signed 1/9/47

X

G17384

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131 C

G17384 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2499 Druid Hill Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2499 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) **FULL NAME** Blanche Reeder Brooks

3 (b) If veteran, name war
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Benjamin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27 1883

8. AGE: Years 63 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace St. Mary's Co. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Dickens
13. Birthplace North Carolina

MOTHER
14. Maiden Name Rebecca Summerville
15. Birthplace St. Mary's Co. Md.

16 (a) Informant Mrs. Sarah Proctor
(b) Address 2544 Pennsylvania Ave.

17 (a) Burial (b) Date thereof Jan. 11, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lucy V. Holland
(b) Address 1681 Druid Hill Ave.

19 (a) JAN 11 1947 Huntington Williams M.D.
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 7 January 1947, at 8:45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 Jan 1947 to 7 Jan 1947 and that I last saw h[illegible] alive on 7 Jan 1947.

| Immediate cause of death | Duration |
|---|---|
| Chronic Nephritis | 1944 |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Gaston Cole M. D.
Address 506 Penna Ave. Date signed 9 Jan 47

VS 150

G47385 BCH F64658

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

108

Registered No. G47385

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 618 E. 28th St.
(c) Hospital or institution:
9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 E. 28th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Erlene Rice

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1942

8. AGE: Years: 4 | Months: 1 | Days: - | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Weldon Rice
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Adeline Sneed Rice
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Adeline Rice
(b) Address 618 E. 28th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 13, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lee A. Stallard
(b) Address 1691 Druid Hill Ave.

19 (a) Date received by Local Registrar JAN 11 1947 (b) Registrar Huntington Whitehead, M.D.

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Jan 10 1947, at 8A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1947, to Jan 10 1947, and that I last saw her alive on Jan 10 1947.

| Immediate cause of death | Duration |
|---|---|
| Lobar Pneumonia | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. D. Woolridge M. D.
Address Eldridge Md. Date signed 1-10-47

VS 150

G47386

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 117a

G47386 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution:
Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. 3 (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1823 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Robert Cromartie

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Negro | Married |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-21-1901

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 45 46 | 9 10 | 11 17 | hr. min. |

9. Birthplace Lumberton, N. C.
(Town, county, and state)
10. Usual Occupation Cement finisher
11. Industry or business

FATHER
12. Name Simps Cromartie
13. Birthplace Lumberton, N.C.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Laurene Cromartie
(b) Address 1823 Madison Ave.

17 (a) Burial (b) Date thereof Jan. 13, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bal. Shark Cem.
Location Baltimore, Md

18 (a) Funeral director Mrs. Lou. H. Holland
(b) Address 1631 Druid Hill Ave

19 JAN 11 1947 Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 1-8 1947, at 5:06 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-7 1947, to 1-8 1947, and that I last saw him alive on 1-8 1947.

| Immediate cause of death | Duration |
|---|---|
| Uremia | |
| Acute nephritis | |
| Due to | |
| Due to | |
| Other Conditions Peptis ulcer | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. R. L. Jackson M. D.
Address 1514 Division St Date signed 1-10-47
Baltimore Md 130

VS 150

G47387 BCH D66285 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 161a Registered No. G47387

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore Glen Arm (If outside city or town limits, write RURAL and give town)
(d) Street No. Edgerton Rd Rt 2 (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Linda Dolores Nevhauser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/27/46

8. AGE: Years | Months | Days: 14 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Vernon Gilbert Neuhauser
13. Birthplace Baltimore, Md

MOTHER 14. Maiden Name Dolores Virginia Schneider
15. Birthplace Baltimore, Md.

16 (a) Informant Mother
(b) Address Glen Arm Route 2

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-12-47 (month) (day) (year)
(c) Cemetery or crematory Union Chapel Cem
Location Harford Co Md

18 (a) Funeral director Herbert J Krech
(b) Address 5305 Harford Rd

19 JAN 11 1947 (Date rec'd by registrar) (b) Hamilton for Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/10/1947 at 5:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/29/1946 to 1/10/1947 and that I last saw him alive on 1/10/1947.

Immediate cause of death: Respiratory Failure — Duration
Due to Atelectasis
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature
Address Date signed 1/10/47 M.D.

VS 150

G47388

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 92c

Registered No. G47388

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4620 Belair road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4620 Belair road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William F. Engelbrecht Sr

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Mathilda Engelbrecht
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | | 7 | hr. min. |

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Beer Brewer
11. Industry or business Retired

MOTHER
12. Name Dont Know
FATHER
13. Birthplace Germany

MOTHER
14. Maiden Name Dont Know
15. Birthplace Germany

16 (a) Informant Mrs. Pauline Hirt Granddaughter
(b) Address 4622 Belair Road

17 (a) Burial (b) Date thereof Jan. 11-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location City

18 (a) Funeral director Hillside Funeral Home
(b) Address 2008 Orleans St

19 (a) Filed JAN 11 1947 (b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 1947, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1945 to Jan 8 1947 and that I last saw him alive on Jan 4 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Embolism | 1 hr. |
| Due to Rheumatic Endocarditis | |
| Due to — | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. B. Hardesty
Address 4610 Belair Rd Date signed 1/10/47

V S 150

547389

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 55E

Registered No. G47389

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 15 S. Elwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 S. Elwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Elizabeth Hoffmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Valentine H. Hoffmann

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Feby 5 1903

8. AGE: Years 43 | Months 11 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER 12. Name John A Martin

13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Kahler

15. Birthplace Germany

16 (a) Informant Valentine H. Hoffmann

(b) Address 15 S Elwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 13- (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location City

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2008 Orleans St

19 JAN 11 1947 (Date rec'd by registrar) (b) Transcription for Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 9th 1947, at 11 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from January 7th 1940 to Jan 9th 1947 and that I last saw h alive on 19

Immediate cause of death (a) Lymphatic Carcinoma — Duration 7 yrs

Due to (b) Lymphatic Carcinoma — Duration 3 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Angela E. Link M.D. M. D.

Address 2211 E. Lake Ave. Date signed 1/10/47

V S 150

G17390

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93

G47390 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1811 McCulloh St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 McCulloh St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Sarah Carter Dunn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Frank Dunn (deceased) | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 4 1856

8. AGE: Years 91 | Months 0 | Days 9 | If less than one day hr. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name George Carter

13. Birthplace Georgetown D.C.

MOTHER 14. Maiden Name Margaretta Sharpe

15. Birthplace D.C.

16 (a) Informant Christina Tansley

(b) Address 1811 McCulloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-12-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Glen

Location Balto.

18 (a) Funeral director Jesse W. Reddan

(b) Address 426 W. Biddle St

19 JAN 11 1947 (Date received by Registrar) (b) Huntington Millionaire M.D. Address 1642 E. Monument St Date June 12/47

VS 150

**MEDICAL CERTIFICATION** 30

20. DATE OF DEATH Jan 10 1947, at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1947, to Jan 10 1947, and that I last saw h[illegible] alive on Jan 9 1947.

| Immediate cause of death | Duration |
|---|---|
| Myocarditis | |
| Due to Arteriosclerosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Fisher M. D.

G47391

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. G47391

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 523 Robert St.
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 523 Robert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Margie Ann Stanley

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Col. | Single |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/21/1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 3 | 17 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Alfred Stanley
13. Birthplace Md.

MOTHER
14. Maiden Name Alverta Summerville
15. Birthplace Md.

16 (a) Informant Gertrude Wilson
(b) Address 523 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/11/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location Brooklyn, Md.

18 (a) Funeral director Elroy C. Wilson
(b) Address 1000 Brantly Ave.

19 (a) 1/11/47 (Date received by registrar) (b) Registrar

VS 150

1/8/47 **MEDICAL CERTIFICATION** 10 AM

**20. DATE OF DEATH** 1/8/47 19 at 10 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 1/3/47 to 1/8/47 19 , and that I last saw h alive on 1/8/47.

Immediate cause of death

Due to Cerebral Hemorrhage — Duration 1 day

Due to

Other Conditions Hypertensive

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. C. McKenna M. D.

Address 1131 Harlem Ave. Date signed 1/9/47

1914

G47392

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

166

Registered No. G47392

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 5 months
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Pa (b) County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. 1839 N. 20th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Edward Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Freda Mae Johnson

6 (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1906

8. AGE: Years 40 | Months 10 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace Chester S. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jake Price
13. Birthplace S. C.

MOTHER
14. Maiden Name Caroline Thompson
15. Birthplace S. C.

16 (a) Informant Freda Mae Johnson
(b) Address 1039 Harford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/11/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Ave

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION** 20

**20. DATE OF DEATH** January 6, 1947, at 10 A M

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Multiple bullet wounds, Hemorrhage into abdominal cavity a

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-6-47 at 9.30 A M.
(b) Where did injury occur? 929 N. Eutaw St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms

23. Signature Howard J. Waldeck M.D. Medical Examiner.
Date signed 1-6-47

VS 151

X

G47393

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G47393

CWK-107272

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
64- 7- 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2625 W. Dulaney Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
George Gerwig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29-1882

8. AGE: Years 64 | Months 7 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Gerwig (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary McComas
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 13/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director George L. Schwab
(b) Address 7101 Frederick Ave

19 (Date received by registrar) JAN 11 1947 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9 1947, at 11:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 3 1947, to Jan. 9 1947, and that I last saw h. alive on Jan. 9 1947

Immediate cause of death: Pulmonary Tuberculosis, far-Advanced — Duration: Unknown
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Refused

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Hunt M. D.
Address Balt. City Hosp. Date signed 1-11-47

V S 150

G47394

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 111c

G47394 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Olivia & Caroline
(c) Hospital or institution: St. Joseph's Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Baltimore, Md. 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 726 S. Wolfe St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARTIN LASECKI

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | WIDOWED |

6 (b) Name of husband or wife HELEN
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) SEPTEMBER 3, 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 64 | 4 | | hr. min. |

9. Birthplace POLAND (Town, county, and state)
10. Usual Occupation GROCER
11. Industry or business GROCER

FATHER
12. Name WILLIAM LASECKI
13. Birthplace POLAND

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace POLAND

16 (a) Informant MR ANDY LASECKI
(b) Address 726 S. WOLFE STREET.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 13, 1947 (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS
Location MT. CARMEL ROAD.

18 (a) Funeral director M. J. Radomski & Son
(b) Address 1805 Eastern Avenue

19 (a) JAN 11 1947 (b) Received by registrar Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/10/1947, at 10 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/9 1947 to 1/10/1947, and that I last saw him alive on 1/9 1947

| Immediate cause of death | Duration |
|---|---|
| CARDIO-Respiratory Failure | |
| Due to Pulmonary Edema | |
| Due to | |
| | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard A. Young M. D.
Address St. Joseph Hosp. Date signed 1/14/47

X

VS 150

G47395

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 309

G47395 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Gruns
(c) Hospital or institution:
Univ. Hosp—
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 W Lee Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Kelly

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years 41 | Months | Days | If less than one day hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER 12. Name James Kelly
13. Birthplace Va

MOTHER 14. Maiden Name Sarah Johnson
15. Birthplace Va

16 (a) Informant Thomas Kelly
(b) Address 617 W Lee St

17 (a) Burial (b) Date thereof 1/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.D. Co Md

18 (a) Funeral director Isaac L. Bowman Son
(b) Address 1084 W Montgomery St

JAN 11 1947 (a) (b) Hampton Williams MD
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-6 1947, at 7.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 1-6 1947.
and that I last saw him alive on 1-6 1947.

Immediate cause of death TB Meningitis — Duration

Due to —

Due to —

Other Conditions TB Pleurisy
Probable syphilis Hydrocephalus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: TB Meningitis TB Pleurisy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Geo K Dugge MD
Address Univ. Hosp. Date signed 1/9/47

VS 150

14

17396

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

166

Registered No. G47396

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 Oak Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Morton

3 (b) If veteran, name war: MERCHANT MARINE
3 (c) Social Security Account No. 220-15-3819

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: SINGLE
6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3-24-1923

8. AGE: Years 19 | Months 9 | Days 17 | If less than one day ... hr. ... min. 1/2

9. Birthplace BALTIMORE Md
(Town, county, and state)

10. Usual Occupation Merchants Marine
11. Industry or business

FATHER
12. Name Leslie Morton
13. Birthplace Va

MOTHER
14. Maiden Name Effie ?
15. Birthplace Va

16 (a) Informant Effie Morton
(b) Address 100 Oak St Dundalk Md

17 (a) Burial (b) Date thereof 1 14 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A.A. Co. Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

19 JAN 11 1947 Huntington Williams, M.D. Registrar
(Date received)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10, 1947 at 5:10 A. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wound of Brain
Intracranial Hemorrhage
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-10-47 at 12 a. M.
(b) Where did injury occur? 117 Valmar Avenue Funkstown
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 1-10-47

VS 151

47397

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 167

G47397 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 Bruce Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William A. Smith

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| World War 2 | — |

| 4. Sex | 5. Color or race | 6 (a) Single, ~~married, widowed, or divorced~~ |
|---|---|---|
| Male | Colored | Single |

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 13-1923

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 23 | 10 | 26 | hr. min. |

9. Birthplace Tarboro, North Carolina
(Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business

FATHER
12. Name Columbus Williams
13. Birthplace Greenville, N. C.

MOTHER
14. Maiden Name Clara Smith
15. Birthplace , N. C.

16 (a) Informant Clara Smith
(b) Address 510 Wagner St, Tarboro N.C.

17 (a) Removal (b) Date thereof 1-12-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Tarboro — Conn
Location TARBORO. NORTH-CAROLINA

18 (a) Funeral director Williams & Jackson
(b) Address 916 Pendleton ave

19 (a) JAN 11 1947 (b) Handling for Williams
(Date rec'd by registrar)

VS 151

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** January 9 1947, at 11 P. M.

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/9/47 at 11:05 P. M.
(b) Where did injury occur? Penna. Ave. & Pitcher St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Sharp instrument

23. Signature Howard J. Mendelsohn M.D.
Medical Examiner.
Date signed 1-10-47

G17398

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G17398

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1623 Ashland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1622 Ashland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estella Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Joseph Butler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29, 1882

8. AGE: Years 64 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles Andrews
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Jane Turner
15. Birthplace Md.

16 (a) Informant Joseph Butler
(b) Address 1622 Ashland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/47 (month) (day) (year)
(c) Cemetery or crematory Laurel Cemetery
Location

18 (a) Funeral director Mrs. Ott A. Elliott Dept
(b) Address 1299 N. Carlton St.

19 (Date received by registrar) JAN 11 1947 Huntington for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8, 1947, at 1 52 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/9 1946 to 1/8 1947 and that I last saw h.er alive on 1/8 1947

Immediate cause of death
hypertensive cardio-renal disease
Due to (Cardiac failure)
Due to
Other Conditions gastric ulcer
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

| Duration |
|---|
| 2 yrs |

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rayner Browne M.D.
Address 1500 E. Madison St Date signed 1/9/47

VS 150

G47399

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

G47399 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1628 E. Eager St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 E. Eager St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Horace

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1886

8. AGE: Years 60 | Months 1 | Days 4 | If less than one day hr. min.

9. Birthplace Fauquier Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Louis Haley
13. Birthplace Va.

MOTHER
14. Maiden Name Sallie Myers
15. Birthplace Va

16 (a) Informant John Haley
(b) Address 1628 E. Eager St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof January 14 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mrs. Ott. A. Fellenbaugh
(b) Address 1129 N. Caroline St.

19 (a) JAN 11 1947 (Date rec'd by registrar) Huntington Williams Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-9-47 1947 at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15- 1946 to 1- 1947 and that I last saw him alive on 1-8- 1947

Immediate cause of death: Cardiac Renal Disease — Duration: unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Carpien M. D.
Address 611-N. Caroline Date signed 1-10-47

VS 150

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G47400

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G47400

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Harford Rd. & Herring Run.
(c) Hospital or institution:
Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2013 E Fayette Boulevard.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Thomas Kozak

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | S. |

6 (b) Name of husband or wife NONE.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1939

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 7 | 1 | 12 | hr. min. |

9. Birthplace Baltimore Balt. Co. Md.
(Town, county, and state)
10. Usual Occupation student.
11. Industry or business —

FATHER
12. Name Paul Kozak.
13. Birthplace Russia

MOTHER
14. Maiden Name Dorothy Michaszki.
15. Birthplace Baltimore

16 (a) Informant James Krolczyk.
(b) Address 2013 E Fayette Boulevard.

17 (a) Burial (b) Date thereof 1-13-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore Md.

18 (a) Funeral director George R Weber
(b) Address 706 S Ann St.

Date received (month) (day) (year) (b) Thurston Williams, M.D.
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11 1947 at 5:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 30, 1946 to Jan. 11 1947, and that I last saw him alive on Jan. 11 1947

| Immediate cause of death | Duration |
|---|---|
| Heart Failure | |
| Due to Uremia. | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Hosp. Date signed 1/14/47

V S 150

G47401 G47401

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. none
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anne Merson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years 69 | Months 4 | Days 30 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Charles Merson
13. Birthplace Md.

MOTHER
14. Maiden Name Eliz. Lilly
15. Birthplace Md.

16 (a) Informant Mrs. Edgar Slater
(b) Address 1116 Woodbine Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/13/47 (month) (day) (year)
(c) Cemetery or crematory St. John's Cemetery
Location Ellicott City, Md.

18 (a) Funeral director Easton Sons
(b) Address Ellicott City, Md.

19 (a) Huntington Williams, M. Registrar
(Date rec'd by registrar)

2 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-11 1947, at 6:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10 1947, to 1-11 1947, and that I last saw h[illegible] alive on 1-11 1947.

Immediate cause of death Cardiac Failure — Duration

Due to arteriosclerotic Cardiovascular Disease

Due to

Other Conditions Possible Pernicious Anemia.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Beverleman

Address Univ. Hosp. Date signed 1-11-47

X

Burial Certificate G-68375 Sec. 507767

G47402

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

159

Registered No. G47402

Type or print the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2703 Bonyl Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Girl Reed.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-9-47.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 2 | hr. min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward Reed
13. Birthplace Md.

MOTHER
14. Maiden Name Rosalie Ward
15. Birthplace Md

16 (a) Informant Reeds.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 11/47 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Edmondson Ave.

18 (a) Funeral director John A. Miller
(b) 1947 2334 Jefferson St. Huntingdon Williamsport, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH Jan. 10 1947 at 11.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 9 1947 to Jan. 10 1947 and that I last saw h[illegible] alive on Jan 10 1947.

| Immediate cause of death | Duration |
|---|---|
| Atelectasis, | |
| Due to Premature | 36hrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Johns Hopkins Hosp. Date signed 1-11-47 M. D.

VS 150

X

G47403 BALTIMORE CITY HEALTH DEPARTMENT G47403
CERTIFICATE OF DEATH 181 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2116 Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Robert D. Kidd (Robert Daniel Kidd)

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6 - 1925

8. AGE: Years 21 | Months 4 | Days 4 | If less than one day: hr. min.

9. Birthplace Laurinburg, N. C. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Seaboard Railway

FATHER
12. Name Tugalo Madison Kidd
13. Birthplace S. C.

MOTHER
14. Maiden Name Blanche Daniel
15. Birthplace Georgia

16 (a) Informant Mr. Walter T. Kidd, brother
(b) Address 2116 N. Charles St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/11/47 (month) (day) (year)
(c) Cemetery or crematory Spring Hill Cem.
Location Wagram, N. C.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 12 1947 (Date received by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10 1947 at 7 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-9-47 19 to 1-10-47 19, and that I last saw him alive on 1-10-47 19

Immediate cause of death: Peripheral vascular collapse and Toxemia — Duration

Due to 1st 2nd and 3rd degree burns of head, neck, trunk + upper limbs.

Other Conditions Alcoholic intoxication
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident 1/12/47
(b) Date of occurrence Jan. 10/47 about 6-7 P M
(c) Where did injury occur? Baltimore Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury Bed linen caught fire from

23. Signature John F. Noguera, M.D.
Address Maryland General Hospital Date signed 1/11/47

VS 150

For C. J. Zebrowski by Thomas J. Keenan, M.D.

BCH

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47404 B61268 G47404 Registered No. 153

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 327 E. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Gary Eugene Clites

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 31st 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 2 | 10 11 | hr. min. |

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Arthur R. Clites

13. Birthplace Cumberland Md.

MOTHER 14. Maiden Name Ruby N. Aldredge

15. Birthplace Roanoke Va.

16 (a) Informant Arthur R. Clites

(b) Address 327 E. Lafayette Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/12/47 (month) (day) (year)

(c) Cemetery or crematory Plintstone

Location Md

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul st.

19 (a) JAN 12 1947 (Date rec'd by registrar) Registrar for Williams M.D. Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan 11 1947 at 10 45 A.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from 12-29 1946 to 1-11 1947 and that I last saw h alive on 1-11 1947

| Immediate cause of death | Duration |
|---|---|
| Marasmus | 1 week |
| Due to Malnutrition | 6 weeks |
| Due to Exfoliative Dermatitis | 6 weeks |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

**23.** Signature Jno Emmons M. D.

Address Sinai Hosp Date signed

VS 150

G47405

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G47405 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2752 Maryland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 D
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2752 Maryland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Cornelia Gardner Hoot

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Henry L
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 4 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 4 | | hr. min. |

9. Birthplace Pittsburgh Pa (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

**FATHER**
12. Name Charles Gardner
13. Birthplace Pa

**MOTHER**
14. Maiden Name Mary Beeler
15. Birthplace Pa

16 (a) Informant Ida B Gardner
(b) Address 2752 Maryland Ave

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 1/14/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1017 Pennsylvania Ave

19 (a) 1947 (Date filed by registrar) Burlington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 1947, at 69 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1946 to Jan 11 1947.
and that I last saw her alive on Jan 10 1947.

| Immediate cause of death | Duration |
|---|---|
| Chronic Myocarditis | |
| Due to Arteriosclerosis | |
| Due to Cerebral hemorrhage | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Wolfe M. D.
Address 1331 E Chase St Date signed 1-11-47

VS 150

G47406

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G47406 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1014 S. Paca St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 S. Paca St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Emma V. Long

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16th 1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 4 | 15 | hr. min. |

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER 12. Name William Downs
13. Birthplace Md.

MOTHER 14. Maiden Name Laura Hartlove
15. Birthplace Md.

16 (a) Informant Mrs. Robert Bayer
(b) Address 1014 S. Paca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/14/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 217 St. Paul St

19 (a) 1/9 1947 (Date received by registrar) (b) Signature of registrar for Williams Hill

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 1947, at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Jan 11 1947 and that I last saw h[illegible] alive on Jan 11 1947.

| Immediate cause of death | Duration |
|---|---|
| Arteriosclerosis C.V.D | 2 years |
| Arteriosclerosis Thrombosis — | 2 weeks |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Schonfeld
Address 331 Arunah Date signed 1/11 1947

Schonfeld X

VS 150

G47407

G47407

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 43a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 416 W. Pratt St
(c) Hospital or institution: H

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 416 W. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah E. Mathies

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband Frank Mathies

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7th 1860

8. AGE: Years 86 | Months 11 | Days 3 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business —

FATHER
12. Name J. H. Libbey
13. Birthplace Maine

MOTHER
14. Maiden Name Sarah (Unknown)
15. Birthplace Md.

16 (a) Informant Mrs. Ethel L. Shaine
(b) Address 416 W. Pratt St.

17 (a) Burial (b) Date thereof 1/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

(c) 1-9 1947 Huntington Williams M.D. Registrar
(Date received by registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10th 1947 at 2:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-30 1946, to 1-10 1947, and that I last saw her alive on 1-9 1947

| | Duration |
|---|---|
| Immediate cause of death: Cerebral Hemorrhage | 11 days. |
| Due to: Hypertension and arteriosclerosis | ? ? |
| Due to: | |
| Other Conditions: — | |

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Harrell Pearce M. D.

Address 313 Med. arts Bldg Baltimore, Md Date signed 1-11-47

G47408

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47408 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Rogers Ave
(c) Hospital or institution: Home for Aged of Methodist Church
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogers
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William McCullough

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NK

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Amanda
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Feb 18 1853

8. AGE: Years 93 | Months 11 | Days 23 | If less than one day hr. min.
9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business

FATHER
12. Name: James McCullough
13. Birthplace: Baltimore Co Md

MOTHER
14. Maiden Name: Elizabeth Hempstone
15. Birthplace: Baltimore Md

16 (a) Informant: Mrs Mary E Coates
(b) Address: 2211 Rogers Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/14/47 (month) (day) (year)
(c) Cemetery or crematory: Mt Olivet
Location: Baltimore Md
18 (a) Funeral director: Wilmer Cole Frye
(b) Address: 1217 E Fort Ave
19 (a) Date received by registrar: Justice for Williams M.D.

JAN 15 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 1947, at 6:24 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1947 to Jan 10 1947 and that I last saw him alive on Jan 10 1947.

| Immediate cause of death | Duration |
|---|---|
| Myocardial insufficiency | 8 days |
| Due to | |
| Arteriosclerosis | 40 yrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur J Davies M. D.
Address 800 N 33rd St Date signed 1-11-47

VS 150

Write the causes of death clearly and legibly. Physicians: please write plainly.

G47409

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47409 Registered No. 193E

Write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3415 Falls Road.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3415 Falls Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank J. Blessing

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | white | widower |

6 (b) Name of husband or wife Veronica B. Blessing
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 7 | 27 | hr. min. |

9. Birthplace Maryland.
(Town, county, and state)
10. Usual Occupation Retired.
11. Industry or business Lt. Balto City Fire Dept

FATHER
12. Name Charles Blessing.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Mary ?
15. Birthplace Maryland.

16 (a) Informant Mrs. Josephine M. Adams.
(b) Address 3416 Falls Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 13/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Cahenman & Donovan.
(b) Address 3615-17 Chestnut Ave

19 (c) 1947 Huntington Williams, M.D. Registrar
(Date filed by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 9, 1947, at 4 50 M

21. I certify that (I) occurred on the date above stated; that I attended deceased from Jan 1st 1944 to Jan 9th 1947 and that I last saw him alive on Jan 9th 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral Thrombosis | 3 years. |
| Due to Arteriosclerosis | 7 y. |
| Chronic Bronchial Asthma. | 7 y. |
| Due to Primary Gangrene of right Lung | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. A. Lillard M. D.
Address 3614 Falls Rd Date signed

X

VS 150

G47410

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47410 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 2211

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits write RURAL and give township)
(d) Street No. 2018 E Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Sarah ~~Lebersky~~ LEBERSKI

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Ike
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Nearest Relative
(b) Address

17 (a) Burial (b) Date thereof 1-12-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Philadelphia Rd & Bowleys Lane

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St

19 (a) (Date rec'd by local registrar JAN 13 1947) (b) Huntington Williams, Registrar

VS 191

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 9th 1947, at 6:16 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-
Due to Vascular Disease
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G. Reich M.D.
Medical Examiner.
Date signed Jan 10, 1947

G47411 — BALTIMORE CITY HEALTH DEPARTMENT — G47411

# CERTIFICATE OF DEATH 194a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2513 Shirley Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2513 Shirley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham P Friedman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER 12. Name Hyman

13. Birthplace Russia

MOTHER 14. Maiden Name Fruma Cather

15. Birthplace Russia

16 (a) Informant Milton Friedman

(b) Address 2513 Shirley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-12-47 (month) (day) (year)

(c) Cemetery or crematory

Location Mt Prospect Herring Run

18 (a) Funeral director Jack Lebin Inc

(b) Address 1429 E Baltimore St

19 (a) 1-12-1947 (b) Filed by registrar Arlington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-10-1947 at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14, 1939 to 1/10/47 19

and that I last saw him alive on Jan. 10, 1947.

Immediate cause of death Coronary Thrombosis

Due to

Due to

Other Conditions Arteriosclerosis Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration about one wk. (Last attack)

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Nathaniel Lynch, M.D.

Address 1810 Eutaw Pl. Date signed 1/10/47

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

X

G47412 BC# 966922

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G47412 Registered No. 104a

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address MONUMENT ST
(c) Hospital or institution SINAI HOSPT
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2600 LOYOLA NORTHWAY
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** BABY HOWARD PAUL SISGOLD

**3 (b) If veteran, name war**

**3 (c) Social Security Account No.**

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | WHITE | SINGLE |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 30, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 13 12 | hr. min. |

9. Birthplace BALTO MD
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name MORRIS SISGOLD
13. Birthplace BALTO. MD

MOTHER
14. Maiden Name TILLYE GREENBERG
15. Birthplace BALTO. MD

16 (a) Informant HOSPT RECORDS
(b) Address

17 (a) BURIAL (b) Date thereof 1-12-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location PHIL. RD. - HAMILTON AVE

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO ST

19 (a) 1-12-1947 Huntington Williams, M.D. Registrar
(Date received) (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-11-47 19 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11-47 to 1-11-47 and that I last saw h[illegible] alive on 1-11 19 47.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | 4 hours |
| Due to Upper respiratory infection | 12 hours |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Organs normal

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jon Emmd M. D.
Address [illegible] Date signed

VS 150

G47413

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1937 G47413 Registered No.

Visiting at: 3401 Walbrook Ave Balto., Md.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3401 Walbrook Ave
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Visiting here.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Somerset Co.
(c) City or town Princess Anne (If outside city or town limits, write RURAL and give town)
(d) Street No. Beechwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

**3 (a) FULL NAME** Florence C. Henderson

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| — | — |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife late John R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 8 | 17 | hr. min. |

9. Birthplace Fairmount Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER 12. Name Henry F. Shelton
13. Birthplace Va

MOTHER 14. Maiden Name Elizabeth C Holland
15. Birthplace Md

16 (a) Informant Mrs. Gertrude Bilmire
(b) Address 3401 Walbrook ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 13-1947 (month) (day) (year)
(c) Cemetery or crematory —
Location Onamock Va

18 (a) Funeral director Geo. L. Beyer Jr
(b) Address 512 Hollins St

19 (a) JAN 12 1947 (Date rec'd by registrar) Registrar Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 10 a.m. 1947, at 1 30 p.m.

21. I certify that I took charge of the remains described above, held an Susp. Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mercer M.D. Medical Examiner.
Date signed 1-10-47

VS 151

G47414 G47414

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 723 Springfield Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 723 Springfield Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Miller

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Joseph.

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Aug. 18 1879

8. AGE: Years 67 Months 4 Days 20 If less than one day ____ hr. ____ min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Pisinski
13. Birthplace Poland.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Joseph Miller
(b) Address 723 Springfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/13/47 (month) (day) (year)

(c) Cemetery or crematory Holy Rood.
Location Belair Rd.

18 (a) Funeral director John L. Hoban
(b) Address 300 E. Balto St.

19 1947 (b) Registrar
(Date received by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1946 to Jan. 7 1947 and that I last saw h[illegible] alive on Jan. 7 1947

| Immediate cause of death | Duration |
|---|---|
| Hypertensive cardio vascular disease | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Everett Jr. M. D.
Address 36 York Ct. Date signed 1-10-47

V S 150

Huntington Williams, M.D.

X

G47415

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 24c

G47415 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave.
(c) Hospital or institution:
Church Home & Hospt.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days) 74 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 Mt. Royal Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Carroll Brown

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| World War I | — |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | S |

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12/8/1893

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | 1 | 3 | hr. min. |

9. Birthplace Norfolk Virg.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Hugh J. Brown
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Mary A. Flynn
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. George J. Lamphere
(b) Address 1608 Mt Royal Ave

17 (a) Burial (b) Date thereof Jan 14 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Mary's Cem
Location Homeland Ave

18 (a) Funeral director John C Mason
(b) Address 3000 Baltimore St

19 (a) 12 1947 (b)
(Date received by registrar) for Williams, Registrar

VS 190

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 1947, at 10:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 11 1946, to Jan 11 1946, and that I last saw him alive on Jan 11 1946

Immediate cause of death Clostridium Welchii Infection — Duration ?

Due to Septal Trauma ? — ? years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John C Mason M. D.
Address Church Home & Hospital Date signed 11 Jan. 47

# HEALTH DEPARTMENT—CITY OF BALTIMORE

G47416 CERTIFICATE OF DEATH 1937 G47416

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 Winston Ave. St. 10 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. 40 How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME HARRIETT BELLE FRENCH

If U. S. Veteran specify WAR

(a) Residence: No. 606 WINSTON AVE. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. Color or Race | 5. Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| FEMALE | WHITE | MARRIED |

5a. If married, widowed, or divorced (or) WIFE of FRANCIS RAYMOND FRENCH

6. DATE OF BIRTH (month, day, year) SEPT. 20, 1886

| 7. AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 60 | 3 | 22 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. HOUSEWIFE

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) BURDEN KANSAS

FATHER

13. NAME WILLIAM TAYLOR FITZ-GERALD

14. BIRTHPLACE (city or town) (State or country) INDIANA

MOTHER

15. MAIDEN NAME EMMA BELLE FRYE

16. BIRTHPLACE (city or town) (State or country) INDIANA

17. INFORMANT FRANCIS RAYMOND FRENCH

(Address) 606 WINSTON AVE

18. BURIAL, CREMATION, OR REMOVAL

Place Bethesda Md. Date Jan 12, 1947

19. UNDERTAKER W. P. Trumpley

(Address) Bethesda Md.

FILED Jan 12 1947 Huntington Williams, M. Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Jan. 12, 1947

22. I HEREBY CERTIFY, That I attended deceased from 1-10-47, 19, to 1-12, 1947.

I last saw her alive on 1-11, 1947. Death is said to have occurred on the date stated above, at 5:45 A.m.

The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| ACUTE CARDIAC DILATATION | 12 HRS |
| Other contributory causes of importance: BRONCHO PNEUMONIA | 36 HRS |
| ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | 7 YEARS |

Was an operation performed? NO Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

NO If so, specify

(Signed) Anthony J. Thomas M. D.

(Address) 4600 York Rd.

X

G47417

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 55E

G47417 Registered No.

Write the cause of death clearly and legibly. Physicians: please write as especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md., (b) County
(c) City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Cordova Apt. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lola Saks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Jacob L. Saks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 6 | 10 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

**FATHER**
12. Name Isaac Jacobs,
13. Birthplace Europe

**MOTHER**
14. Maiden Name Anna Levin,
15. Birthplace Europe

16 (a) Informant Mrs. Emil Crockin
(b) Address Hotel Stafford

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/12/47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris Funeral Home
(b) Address 1202 Eutaw Place

19 (a) 1947 (Filed by registrar) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 1/11 1947, at 2:57 A.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec 23 1946, to Jan 11 1947, and that I last saw h~~im~~er alive on Jan 11 1947

Immediate cause of death Pneumonia Lobar
Secondary Metastasis Lung

| Duration |
|---|
| |
| |
| |
| |

Due to
Due to
Other Conditions Follicular Lymphoblastoma

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Rotter M. D.
Address Sinai Hosp. Date signed 1/11/47

VS 150

G47418

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47418 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 718 E. Coldspring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 718 E. Coldspring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George SPARKAUSKAS

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | W | Widowed |

6 (b) Name of husband or wife Carline
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 9 5 | | hr. min. |

9. Birthplace Lith. (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name ? SPAKAUSKAS
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Petrona Burns
(b) Address 718 E. Coldspring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 13-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Joseph Kasunskas
(b) Address 606 Washington Blvd

19 (a) 1947 (Date rec'd by registrar) Stanton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-9 1947, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-4 1947 to 1-9 1947, and that I last saw him alive on 1-9 1947.

| Immediate cause of death | Duration |
|---|---|
| (a) Acute Cardiac Failure | 10a |
| Due to (b) Bronchopneumonia | |
| Due to (c) Arteriosclerotic Cerebral Disease | 5yr |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Dwight L. Lawrence M. D.
Address 5 E. Washington Blvd Date signed 1/11/47

VS 150

Correct ICD if especially important. Physicians: please write the causes of death clearly and legibly.

G47419
505114

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 55E

G47419
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Queen Anne
(c) City or town Centerville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ethel Anthony

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife J. Howard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-1-1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 59 | 1 | 10 | hr. min. |

9. Birthplace md.
(Town, county, and state)
10. Usual Occupation Home-wife
11. Industry or business

FATHER
12. Name James B. Price
13. Birthplace md.

MOTHER
14. Maiden Name Sarah Wicks
15. Birthplace md.

16 (a) Informant Rhonda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 1/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Chesterfield
Location Centreville, Md.

18 (a) Funeral director Barton Bros.
(b) Address Centreville, Md.

19 (a) Jan 2 1947 (b) Clayton Williams, Registrar
(Date rec'd by reg.)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 11 1947, at 4.20 M A

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 22 1946 to Jan 11 1947, and that I last saw h[illegible] alive on Jan 11 1947

| Immediate cause of death | Duration |
|---|---|
| Carcinomatosis, type undetermined | |
| Due to | |
| Due to | |
| Other Conditions Chronic Brucellosis | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. M. Knight M. D.
Address Date signed

VS 150

Cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

G47420

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G47420 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland D.O.A.
(b) Street address 3614 Belvedere Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3614 Belvedere Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Floyd Chenoweth

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-9884

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Almira L. Rice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1893

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | 2 | 17 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name William W. Chenoweth
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Elizabeth Kerby
15. Birthplace Unknown

16 (a) Informant Mrs Almira L. Chenoweth
(b) Address 3614 W. Belvedere Ave

17 (a) Burial (b) Date thereof 1-13-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore

18 (a) Funeral director Loring Byers
(b) Address 5005 Park Heights Ave
(c) JAN 12 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/10 1947, at 8:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Turbin M.D.
Medical Examiner.
Date signed 1/14/47

X

G47421

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH (92)

G47421 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write as especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1745 Bell St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1745 Bell St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Cecilia R. Flynn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4 1871

8. AGE: Years 75 | Months 4 | Days 6 | If less than one day: hr. min.

9. Birthplace Phila Pa. (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Michael J. Flynn
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Sands
15. Birthplace Ireland

16 (a) Informant Miss Nellie J. Flynn
(b) Address 1745 Bell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-14-1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flynn & Flynn
(b) Address 1476 Light St.

19 1947 (Date rec'd by registrar) Fee $5.00 Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 10 - 1947 at 11:00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1946 to 1/10 1947 and that I last saw h alive on 1/10 1947.

Immediate cause of death: Chronic Endocarditis — Duration: 1 yr

Due to: Arteriosclerosis — Duration: 1 yr

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. B. Wheeler M. D.
Address 1279 Hillsdale Date signed 1/12/47.

VS 150

G47422

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47422 Registered No. 1111c

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp D.O.A
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4211- Audrey Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Arline FANGMANN

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | |

6 (b) Name of husband or wife Theodore L. Fangmann
6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) Oct. 20 1913

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 23 | 2 | 19 | hr. min. |

9. Birthplace Roanoke Va
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name James L. Parker
13. Birthplace Roanoke Va

MOTHER
14. Maiden Name Dora E. Foutz
15. Birthplace Va

16 (a) Informant Theodore L. Fangmann
(b) Address 4211 Audrey Ave

17 (a) Burial (b) Date thereof 1-13-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19. (a) 1947 (Registered by registrar) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** June 8, 1947, at 11:50 P.M.

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 6/10/47

VS 151

G47423

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 55E

G47423 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 6212 Alumore Way
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6212 Alumore Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME James B. Geaslen

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Helen L. Geaslen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 - 6 - 1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 3 | 4 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Inspector
11. Industry or business U.S.Gov.

FATHER
12. Name James S Geaslen
13. Birthplace W. Va.

MOTHER
14. Maiden Name Jennie May Dixon
15. Birthplace Balto.

16 (a) Informant Helen L. Geaslen
(b) Address 6212 Alumore Way

17 (a) Burial (b) Date thereof 1/13/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Laurel Md.

18 (a) Funeral director Selby Zeiler Co.
(b) Address 403 S. Wolfe Street

19 (a) JAN 12 1947 (b) [illegible] M.D.
(Date received by registrar)

VS 190

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10 1947, at 10½ AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 1, 1946, to Jan 10, 1947, and that I last saw him alive on Jan 8 1947

| Immediate cause of death | Duration |
|---|---|
| Myelogenous Leukemia (Blood tests) | 8 months? |
| Due to | |
| Due to | |
| Other Conditions Secondary Anemia | 2 months |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David H. Andrews M. D.
Address 2 Kinship Rd Date signed 1/11/47
Allendale Rd

G47424

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

G47424

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 401 E. Federal St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Clemens

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | Married |

6 (b) Name of husband or wife Clyde Clemens

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 21, 1925

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 21 | 4 | 19 | hr. min. |

9. Birthplace Florence S. Car.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Mc Neil Frierson
13. Birthplace Florence, S. Car.

MOTHER
14. Maiden Name Cleo Wingate
15. Birthplace Florence, S. Car.

16 (a) Informant Mr. Mc Neil Frierson
(b) Address 2345 S. 24th St. Phila Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 12, 1947 (month) (day) (year)

(c) Cemetery or crematory family lot
Location Philadelphia, Pa.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) JAN 13 1947 (Date received by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 1947 at 8:29 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid and subdural hemorrhage (spontaneous)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thomas S. Waters M.D.
Medical Examiner.
Date signed 1-10-47

VS 151

BCH

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

7425 G62564 / 107 Registered No. G17425

Correct age if temporary improvable. If typewriter, please write plainly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1716 N. C Hopel St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1716 N. C Hopel St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ROBERTA J. BEYER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 1946

8. AGE: Years 0 | Months 2 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name George C Beyer
13. Birthplace Balto Md

MOTHER
14. Maiden Name Ethel J. Williamson
15. Birthplace Balto Md

16 (a) Informant George C. Beyer
(b) Address 1716 N. C Hopel St

17 (a) Burial (b) Date thereof Jan 13-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oakland
Location

18 (a) Funeral director Wm. H. & B. M. Walter
(b) Address Pratt & Stricker St

JAN 13 1947 (b) Huntington Williams, M.D.
(Date received by local registrar)

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** January 11 1947 at 10A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1947, to Jan 11 1947, and that I last saw h[illegible] alive on Jan 10 1947.

| Immediate cause of death | Duration |
|---|---|
| Pneumonia, Bronch. | 4 days |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature Joseph Friedman M. D.

Address 206 E. Preston St. Date signed 1-12-47

X

17426

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G47426

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1707 Bruce St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 Bruce St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife William Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15 1869

8. AGE: Years 57 Months 7 Days 26 If less than one day hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation Home maker

11. Industry or business

FATHER
12. Name Aaron Robuck
13. Birthplace Georgia

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Thelma Jackson
(b) Address 1707 N. Bruce St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Md

18 (a) Funeral director George G. Nelson
(b) Address 1303 Pennsylvania Ave.

JAN 13 1947 (Date received by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION 47

20. DATE OF DEATH Jan 10 1947, at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1946, to Jan 10 1947 and that I last saw h[illegible] alive on Dec 19 1946.

| | Duration |
|---|---|
| Immediate cause of death Cardio Vascular Disease | 9 mos 24 |
| Due to Cerebral Hemorrhage | 4 days |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. William Frey M.D.
Address 1928 Penna Ave Date signed 1/11/47

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G47427

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 126

Registered No. G47427

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1038 MALDEIS. ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Emma Parks

3 (b) If veteran, name war

3 (c) Social Security Account No. 178-19-4368

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| FEM | WHITE | WIDOW |

6 (b) Name of husband or wife JOS. PARKS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 24- 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 9 | 17 | hr. min. |

9. Birthplace VIRGINIA.
(Town, county, and state)
10. Usual Occupation MILL WORKER
11. Industry or business MT VERNON MILLS

FATHER
12. Name JOHN SHEIVK.
13. Birthplace VA.

MOTHER
14. Maiden Name MARY JENKINS.
15. Birthplace VA.

16 (a) Informant GRACE HAYDEN
(b) Address 1038 MALDEIS. ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN 14- 47 (month) (day) (year)
(c) Cemetery or crematory OAKLAND CEM.
Location PHILADELPHIA PA.

18 (a) Funeral director Bernard C Harle
(b) Address 121 E West St

19 JAN 13 1947 [illegible]

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan 10 1947 at 3.05 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 1-8 1947 to 1-10 1947, and that I last saw her alive on 1-10 1947

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia | |
| Due to | |
| Due to | |
| Other Conditions Hydrops Fall Bladder Arteriosclerotic Heart Disease (Include pregnancy within 3 months of death) | |

Date of operation 1-8-47
Major findings of operation: Hydrops Gall Bladder
of autopsy: Bronchopneumonia Arteriosclerosis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23.** Signature Elliott J Weichman M. D.
Address Sinai Hosp Date signed 1-10-47

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G47428

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G47428 Registered No.

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home & Hospital 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3323 Leighton Rd.
(If rural give location)
(e) Citizen of foreign country ? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs Mary Epstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24 1869

| 8. AGE: Years | Months | Days | If less than one day: hr. | min. |
|---|---|---|---|---|
| 78 | 8 | 22 | | 18 6 |

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name David Epstein.
13. Birthplace Russia

MOTHER
14. Maiden Name Dora ?
15. Birthplace Russia

16 (a) Informant Mrs Julius Herman (daughter)
(b) Address 3321 Leighton Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-47 (month) (day) (year)

(c) Cemetery or crematory Hebrew Herring Run
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1425 E. Balto St.

19 (a) (Date rec'd by reg.) JAN 13 19 (b) Huntington Williams, Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1947 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9 1947 to Jan 12 1947 and that I last saw h.. alive on Jan 12 1947

Immediate cause of death Congestive heart failure
due to arterial hypertension

| Duration |
|---|
| 4 days |
| |
| 15 yrs |
| 5 yrs |
| |

Due to Hypertensive cardiovascular disease.

Due to arteriosclerotic heart disease
& arteriosclerosis general.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Bachrach M. D.
Address Church Home & Hosp Date signed Jan 13 47

G47429

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓61

G47429 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave. & Dukeland St.
(c) Hospital or institution: West Baltimore Genual Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3919 Bonner Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Meyer Rosen

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Pauline Rosen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1845

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Isaac
13. Birthplace Russia

MOTHER
14. Maiden Name Ida
15. Birthplace Russia

16 (a) Informant Pauline Rosen
(b) Address 3919 Bonner Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-13-47 (month) (day) (year)
(c) Cemetery or crematory Beth Tefiloh
Location Windsor Mill Road

18 (a) Funeral director Jas. Lewis Inc
(b) Address 1429 E Balto St

19 (a) JAN 12 1947 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12, 1947 at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 6, 1947 to Jan. 12, 1947 and that I last saw him alive on Jan. 12, 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardio-respiratory failure | |
| Due to Cerebrovascular accident | |
| Gangrene of Scrotum | |
| Due to Diabetes mellitus | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leon Toby M.D. M. D.
Address West Balto. Gen. Hosp. Date signed 1/12/47

X

VS 150

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G47430

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

737

G47430 Registered No.

Write the causes of death clearly and legibly. Physicians: please write to correct age is especially important.

**1. PLACE OF DEATH:** Un
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2751 Round Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Cherry Hill, Md.

**3 (a) FULL NAME** Woodrow Tyler

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | Colored | child |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 11 | 24 | hr. min. |

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

MOTHER / FATHER
12. Name Robert White
13. Birthplace Virginia
14. Maiden Name Mary Tyler
15. Birthplace Md.

16 (a) Informant Mary Tyler
(b) Address 2751 Round Rd

17 (a) Burial (b) Date thereof 1-13-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Md

18 (a) Funeral director A. Falatiadi
(b) Address 918 Druid Hill Ave

19 (a) (b)
(Date received by Registrar)

JAN 13 1947

VS 150

Huntington Williams, M.D.

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 1-10 1947 at 11:30 PM

**21.** I certify that death occurred on the date above stated; that I attended deceased from 1-2 1947 to 1-10 1947, and that I last saw h.. alive on 1-10 1947.

Immediate cause of death: Respiratory failure — Duration: 1

Due to debilitation

Due to Chronic infection of generalized system; — 6 mos.

Other Conditions Severe anemia

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Hutcheson

Address University Hosp. Date signed 11 Jan 47

X

Dr Rostkowski
1326 Hollins St
G47431

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G47431 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1530 Hollins St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1530 Hollins St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie T. Angelini

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Frank P Angelini

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 6 1866

8. AGE: Years 81 | Months 0 | Days 4 | If less than one day: hr. min.

9. Birthplace Frederick Co Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Daniel M Twomley
13. Birthplace Md

MOTHER
14. Maiden Name Eliza Draper
15. Birthplace Md

16 (a) Informant My Daniel Angelini
(b) Address Tuxedo Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-14-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Geo L. Beyer Jr
(b) Address 1512 Hollins St

19 JAN 13 1947 (Date rec'd by registrar) Hattie Williams, M.D.

VS 190

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10 1947, at 9:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 39 1946 to Jan 10 1947, and that I last saw her alive on Jan 10 1947.

Immediate cause of death: Coronary Occlusion — Duration: ?

Due to Arteriosclerotic Cardio Vascular Disease — Duration: ?

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Carl P Rostkowski M. D.
Address 1326 W Lombard St Date signed 1/13/47

X

G47432

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G47132

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2219 Elsinor Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2219 Elsinor Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** EMILIE B. BITTORF

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widow |

6 (b) Name of husband or wife Henry W. Bittorf
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1864

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | 9 | 5 | hr. min. |

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Lena Winkelman
15. Birthplace Germany

16 (a) Informant Mr. Henry I. Bittorf
(b) Address 2219 Elsinor Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/13/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.
18 (a) Funeral director WM. J. TICHLER & SONS
(b) Address [illegible]
19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 11, 1947; at 12:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 5 1946 to Jan. 11 1947 and that I last saw her alive on Jan. 10 1947.

| Immediate cause of death | Duration |
|---|---|
| Acute Dilitation of heart | 2 days |
| Due to Myocarditis | 14 months |
| Due to Advanced arteriosclerosis - ? | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Grover C. Tibbett
Address 2220 Garrison Blvd. Date signed 1/14/47

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

JAN 13 1947

G47433

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 111c

Registered No. G47433

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1211 Light St
(c) Hospital or institution: So Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 da
(e) Length of stay in Baltimore (yrs., mos., or days) ?

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3109 Gwynns Falls Pkwy (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ida Catharine Wannen

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed or divorced.
6 (b) Name of husband or wife: George R. Wannen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/25/1868
8. AGE: Years 78 | Months 7 | Days 15 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Conrad Keidel
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Leimbach
15. Birthplace Germany

16 (a) Informant Mr. Carl L. Wannen
(b) Address 3908 Gwynns Falls Pkwy.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) (b) Williams, M.D. Registrar

JAN 10 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/10 1947 at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3 1946 to 1-10 1947, and that I last saw h. C alive on 1-10 1947

| Immediate cause of death | Duration |
|---|---|
| Hypostatic pneumonia | |
| Due to Generalized tuberculosis | |
| Due to debilitation | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J Braxton Wirt M. D.
Address 1211 Light St Date signed 1-10-47

VS 150

G47434

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47434 Registered No. 137a

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 413 North Calhoun St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Newman

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | white | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-3-1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 5 | 9 | hr. min. |

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired Sea Captain

11. Industry or business

FATHER 12. Name John Newman

13. Birthplace Maryland

MOTHER 14. Maiden Name Mc Stupes

15. Birthplace Maryland

16 (a) Informant: Mrs. Cora Dudley

(b) Address 413 North Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/47 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150 JAN 13 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 12 1947, at 6:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Jan 12 1947 and that I last saw him alive on Jan 11 1947.

Immediate cause of death Cardiac failure — Duration

Due to Bronchio-pneumonia

Due to Uremia

Other Conditions Adenomyoma of Prostate

(Include pregnancy within 3 months of death)

Date of operation Nov 15, 1946

Major findings of operation Adenomyoma of prostate gland

of autopsy

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Richard C. Norton M.D.

Address Maryland Gen. Hosp. Date signed 1/12/47 M. D.

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47435

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G47435 Registered No.

Please write the causes of death clearly and legibly. Physicians: please report promptly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 101 W. Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ADELE MarieWELLER

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife Harry Weller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 11 | 28 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jacob Klein
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Nichol
15. Birthplace Germany

16 (a) Informant Mr. Harry Weller
(b) Address 101 W. Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) (b) Registrar

JAN 15 1947 Registrar for Millersville, Md.

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 1/11 1947, at 4:10 PM

**21.** I certify that death occurred on the date above stated; that I attended deceased from 10/24 1946 to 1/11 1947. and that I last saw HER alive on 1/11 1947.

| Immediate cause of death | Duration |
|---|---|
| CONGESTIVE HEART FAILURE | 79 DAYS |
| Due to ARTERIOSCLEROTIC HEART DISEASE | |
| Due to | |
| Other Conditions POSSIBLE CIRRHOSIS OF LIVER | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles W. Stewart, Jr. M. D.
Address MD GEN. HOSP. Date signed 1/11/47

X

G47436

G47436 BCH G60881

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 157a

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Williams & Eaton Aves.
(c) Hospital or institution: St. Agnes Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3302 Elgin Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Donald Clay Edmonds, Jr.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| male | white | Single |

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 2 | 8 | hr. min. |

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Donald Clay Edmonds, Sr.
13. Birthplace Md. (Balto.)

MOTHER
14. Maiden Name June Bell
15. Birthplace Md. (Balto.)

16 (a) Informant Mr. Clay Donald Edmonds, Sr.
(b) Address 3302 Elgin Ave.

17 (a) Burial (b) Date thereof 1/14/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JAN 15 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-11 1947, at 10:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-25 1946 to 1-11 1947 and that I last saw h/ alive on 1-11 1947

Immediate cause of death Respiratory Failure — Duration
Due to Hydrocephalus
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry W. Holges M. D.
Address 5 E. Rogers Ave. Date signed X 1-12-47

3 G47437

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 95B

G47437 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Halethorpe
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1929 Woodside Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** EDWARD J. SZECH

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary E. (Hook)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1895

8. AGE: Years 51 | Months 4 | Days 15 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Breadmaker
11. Industry or business: Pittsburgh Plate Glass Co

FATHER
12. Name: Michael Szech
13. Birthplace: Germany

MOTHER
14. Maiden Name: Augusta Dehard
15. Birthplace: Germany

16 (a) Informant: Mrs Mary E Szech
(b) Address: 1929 Woodside Ave. Halethorpe

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan 14 '47 (month) (day) (year)
(c) Cemetery or crematory: Mt Olivet
Location: 2930 Frederick Ave

18 (a) Funeral director: Henry H Wright
(b) Address: 4101 Edmondson Ave

19 (a) (Date received) JAN 13 1947 (b) Huntington Williams Md

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/11 1947, at 11 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1946, to 1/11 1947, and that I last saw him alive on 1/11 1947.

Immediate cause of death: CONGESTIVE HEART FAILURE AND BRONCHOPNEUMONIA — Duration: 40 DAYS
Due to: RHEUMATIC HEART DISEASE
Due to:
Other Conditions: THROMBOCYTOPENIC PURPURA
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Charles W. Stewart Jr. M. D.
Address: MD. GEN. HOSP. Date signed 1/11/47

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

G47438

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G47438

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1017 Parksley Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) yr.
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yr.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 Parksley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Randolph Francis

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W. | married |

6 (b) Name of husband or wife Alice Young Francis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 3 | - | hr. min. |

9. Birthplace England
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Frederick Francis
13. Birthplace England

MOTHER
14. Maiden Name —
15. Birthplace England

16 (a) Informant Hardy L. Francis
(b) Address 1017 Parksley ave

17 (a) Burial (b) Date thereof Jan. 13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Nuttle
(b) Address 4101 Edmondson ave

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 1947, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1946 to Jan 10 1947. and that I last saw h alive on Jan 7 1947

| Immediate cause of death | Duration |
|---|---|
| Sudden fell from chair from leg cramp/ occlusion | few minutes |
| Due to Generalized arteriosclerosis with hypertensive degeneration | + years |
| Due to | |
| Other Conditions Arthritis (osteo) all joints | + years |

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Frederic D. Reiter M. D.
Address 723 Medical Arts Bldg Balto Date signed 1-11-47

VS 150

JAN 13 1947 Huntington Williams, M.D.

X

G47439

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47439 Registered No.

G47439 ✓ 94a

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G47440

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH X 55E

Registered No. G47440

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lyman Park Drive & 31st St.
(c) Hospital or institution: U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 18

2. USUAL RESIDENCE OF DECEASED:
(a) State Michigan (b) County
(c) City or town Rogers City
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Patrick Tupper

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | MARRIED |

6 (b) Name of husband or wife GRACE NAGLE TUPPER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 23rd 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | - | 19 | hr. min. |

9. Birthplace BLANCHARD Michigan (Town, county, and state)
10. Usual Occupation Lighthouse Keeper
11. Industry or business U.S. Coast Guard

FATHER
12. Name CHARLES TUPPER
13. Birthplace MICHIGAN

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace UNKNOWN

16 (a) Informant Wife
(b) Address Rogers City Mich

17 (a) 1-12-47 (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Rogers City - Mich
Location Rogers City Mich

18 (a) Funeral director Adler Funeral Home Inc.
(b) Address 403 E-25th St.

19 (a) JAN 13 1947 (b) Registrar by Thelma Williamson

## MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 11 1947, at 10:46 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 23 1946 to Jan 11 1947, and that I last saw him alive on Jan 11 1947.

| Immediate cause of death | Duration |
|---|---|
| | |
| Due to Lymphosarcoma Reticulum cell | |
| Due to | |
| Other Conditions Embolus, Pulmonary Rt lower lung (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy: As Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joe M. Chisolm M. D.
Address U.S. Marine Hospital Date signed 1/12/47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47441

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G47441 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor & Oakland
(c) Hospital or institution: Ust Bath Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2313 Monticello Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Rudolph H. Beck

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | white | married |

6 (b) Name of husband or wife Charlotte Edna Bartlett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | | | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Purchasing agent
11. Industry or business U. M. H.

FATHER
12. Name Rudolph Beck
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Madeline Zink
15. Birthplace Baltimore County, Md.

16 (a) Informant David B. Beck
(b) Address 2313 Monticello Road

17 (a) Burial (b) Date thereof 1/14/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Frederick Ave. - Balto.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) Huntington Williams (b) Address

JAN 13 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 January 1947 at 3 55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11 Jan 1947 11 Jan 1947 and that I last saw him alive on 11 Jan 1947

| Immediate cause of death | Duration |
|---|---|
| Cardiac Decompensation | |
| Due to Cerebral Hem. | |
| Due to Hypertensive V. Dis. | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury

23. Signature Lester A. Beck Jr. M.D.
Address 1 East Balto Date signed 1/13/47

S-J.R. Davis, by Howard L. Mercein M.D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47442

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 186a

G47442 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1618 Lansing St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 Lansing St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W Busch

3 (b) If veteran, name war W | 3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Ella Busch

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 6 1867

8. AGE: Years 79 | Months 3 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Blender Artist

11. Industry or business

FATHER 12. Name George C Busch

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Sarah Sprole

15. Birthplace Baltimore Md

16 (a) Informant Mrs Sadie Bishop

(b) Address 4718 Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/13/47 (month) (day) (year)

(c) Cemetery or crematory Fairmount

Location Baltimore Md

18 (a) Funeral director Wilhelm & Son

(b) Address 1217 E. Fort Ave

19 (a) Filed JAN 13 1947 (Registrar) by Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 10 1947, at 2:8 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1946 to Jan 10th 1947. and that I last saw h[illegible] alive on Dec 29th 1946.

Immediate cause of death Decompensated Heart

Duration 1 Year and 2 months

Due to General Debility and Arteriosclerosis.

Due to Bedridden 40 th fractured hip

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 8/6

(a) Accident, suicide, or homicide fractured hip-accident.

(b) Date of occurrence November 1946

(c) Where did injury occur? Baltimore Md (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Bedroom (Specify type of place) While at work? no

(e) Means of injury Fell out of bed on floor.

23. Signature Karl Bradford

Address 1623 E. N. Avenue Date signed 1-17-47 M.D.

VS 150

S.C.J. Lubinski, by Thomas J. Carlin, M.D.

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G47443

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G47143

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3330 Cardenas Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County B-
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3330 Cardenas Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche M. Maskell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: David A. Maskell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28th 1881

8. AGE: Years 65 | Months 6 | Days 15 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Eugene Gonlde
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Lucy Myers
15. Birthplace Balto. Md.

16 (a) Informant David A. Maskell
(b) Address 3330 Cardenas Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 13 47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Lansdale Funeral Home
(b) Address 7401 Belair Rd.

19 (a) (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1947 at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1946 to Jan 12 1947 and that I last saw h[illegible] alive on Jan 12 1947

Immediate cause of death

| | Duration |
|---|---|
| Coronary thrombosis | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Stevens M.D.
Address 3407 Eutaw Ave. Date signed 1/13/47

JAN 13 1947

Huntington Williams, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47444

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G47444 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in specially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 723 E. Preston St
(c) Hospital or institution: None
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 723 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes ~~or No~~)
If yes, name country

**3 (a) FULL NAME** Austin Bernard

3 (b) If veteran, name war ?

3 (c) Social Security Account No. 214-16-8795

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | white | ? |

6 (b) Name of husband or wife ?

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) ?

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | | | hr. min. |

9. Birthplace ? (Town, county, and state)
10. Usual Occupation ?
11. Industry or business ?

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Margaret Morgan
(b) Address 723 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 14-1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Road

18 (a) Funeral director Joseph Sause Jr. Inc.
(b) Address 210 Intermediate Ave

19 (a) (b) Registrar
JAN 15 1947 Hamilton Williams, M.D.

V S 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 11 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from January 8 1947 to January 11 1947 and that I last saw h alive on Jan 8th 1947.

Immediate cause of death Coronary Thrombosis — Duration 3 days.
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Karl Traugott M. D.
Address 1623 E. N. Ave. Date signed 1-10-47

X

G47445

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46F

Registered No. G47445

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1016 Brantly Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1016 Brantly Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles West Cease

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Race M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/27/[illegible]

8. AGE: Years 60 | Months | Days 19 | If less than one day hr. min.

9. Birthplace Hagerstown, Md (Town, county, and state)

10. Usual Occupation Handy Man

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant John L Spain

(b) Address 1016 Brantly Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/13/47 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Elroy DeWilson

(b) Address 1000 Brantly Ave

19 (a) (Date received) (b) JAN 13 1947 Registrar

Hunterstown, Williamsport, Md

VS 150

**MEDICAL CERTIFICATION** 7451

20. DATE OF DEATH Jan 10 1947, at 7:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1947 to Jan 10 1947 and that I last saw h[illegible] alive on Jan 10 1947.

Immediate cause of death: Carcinoma of Liver & Metastasis

Duration 6 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]

Address 75 W Baltimore Date signed 1/13/47

G47446

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G47446 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1417 E Eager St.
(c) Hospital or institution: 10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 E. Eager St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lula Ruff

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25 1873

8. AGE: Years 68 | Months - | Days 16 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 13/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Frederick Road.

18 (a) Funeral director Mrs. Pott A. Elliott
(b) Address 1129 N. Caroline St.

19 (a) Filed JAN 13 1947 (Registrar's signature) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-10 1947 at A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-9 1947, to 1-10 1947, and that I last saw h[illegible] alive on 1-9 1947

Immediate cause of death: Chronic Myocarditis

Due to

Due to

Other Conditions: Malignant Hypertension (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: Chronic Myocarditis over 1 yr; 2 years

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Calvin B. Lee Coupe M. D.
Address 1113 N. Caroline St. Date signed 1/11/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G47447

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G47447 Registered No.

Correct age is especially important. Physician: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1826 S. Caroline St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mr. Harry A. Miller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Mollie M. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 31 1869

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 2 | 12 | hr. min. |

9. Birthplace Balto Co (Town, county, and state)
10. Usual Occupation Retd Conductor
11. Industry or business Retired

FATHER
12. Name George W. Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Reinhardt
15. Birthplace Germany

16 (a) Informant Mollie M. Miller
(b) Address 1826 S. Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 15 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Balto Co
18 (a) Funeral director Howard E. Evans
(b) Address 1400 N. Caroline St
19 (a) (Date received) JAN 13 1947 (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/12/1947 at 1.45 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 10/10/1946 to 1/12 1947, and that I last saw him alive on 1/12/1947.

| Immediate cause of death | Duration |
|---|---|
| Cardio-respiratory failure | |
| Due to Diabetic gangrene | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 11/21/46
Major findings of operation: Gangrene 3rd toe - Right leg (gangrene)
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. E. Stevens
Address St. Josephs Date signed 1/12/47 M. D.

VS 150

G47448 Damil

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 E

G47448 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 437 N. Central ave
(c) Hospital or institution: 5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 437 N. Central ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James M Thomas

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Harriett

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2-4-1872

8. AGE: Years 74 | Months 11 | Days 8 9 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland
(Town, county and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Lillie May Forest
(b) Address 437 N. Central ave

17 (a) Burial (b) Date thereof 1 16 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Lebanon Cem
Location Baltimore Md

18 (a) Funeral director William Jackson
(b) Address 916 Pennsylvania ave

19 (a) (b)
(Date rec'd by registrar) Registrar

JAN 13 1947

V S

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 13 1947, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10 1947 to 1-12 1947, and that I last saw h[illegible] alive on 1-10 1947

Immediate cause of death: Carcinoma of Colon — Duration: 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence [illegible] at [illegible] M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. McDaniel M. D.

Address 807 N. Caroline St Date signed 1-13-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Huntington Hill.

X

G47449

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93E

Registered No. G47449

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: Bon Secours Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days): 60 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: Md. (b) County: ---
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 4803 York road
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country:

3 (a) **FULL NAME**: Mr Edmund Joseph Meskill (EDMUND JOSEPH MESKILL)

3 (b) If veteran, name war: -----

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katherine M. Meskill

6 (c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): June 15, 1871

8. AGE: Years: 75 | Months: 6 | Days: 25 | If less than one day: ....hr. ....min.

9. Birthplace: Ireland (Town, county, and state)

10. Usual Occupation: Retired- General Manager

11. Industry or business

FATHER
12. Name: Michael Meskill
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Julia Noonan
15. Birthplace: Ireland

16 (a) Informant: Mrs. Katherine M. Meskill
(b) Address: 4803 York road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1/14/47 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: Old Frederick road

18 (a) Funeral director: Chas. J. Evans & Son Inc.
(b) Address: 118 N. Mt. Royal Ave.

19 (a) (Date rec'd by registrar) JAN 13 1947 (b) Williams Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Jan 12 19 47, at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1947, to Jan 12 1947, and that I last saw h[illegible] alive on Jan 10 1947.

| Immediate cause of death | Duration |
|---|---|
| Congestive heart failure | |
| Due to: Generalized arteriosclerosis | |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: William F. Keim, M.D. M. D.
Address: 3 E. Lanvale St. Date signed: 1/14/47

X

G47450

BCH G66562

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 159

G47450
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution W. B. & A. Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 Mc Henry (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Anna Eyglehart

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 28, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 0 | 0 | 15 | hr. min. |

9. Birthplace W. B. & A. Hospital
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Owen Eyglehart
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Viola Henning
15. Birthplace West Virginia

16 (a) Informant Mother
(b) Address 1810 McHenry St.

17 (a) Burial (b) Date thereof Jan. 13 '47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location 3801 Frederick ave

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Ave

JAN 13 1947 (Signature of local registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1947, at 3:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h[illegible] alive on Jan 12 1947

Immediate cause of death Cardiac failure — Duration

Due to Postmaturity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph M. Keith M. D.
Address West Baltimore General Hospital Date signed Jan 12 1947

VS 150

X

Write the causes of death clearly and legibly. Exact age is especially important. Physicians: please write t

17451

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93C

Registered 17451

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 622 E. 36th St.
(c) Hospital or institution:
9-13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 622 E. 36th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Katherine Lentz

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, ~~married, widowed, or divorced~~

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11 1882

8. AGE: Years 64 | Months 8 | Days - | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Adam Lentz
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Lena Wagner
15. Birthplace Baltimore Md

16 (a) Informant Hebert Lentz
(b) Address 622 E 36th St

17 (a) Burial (b) Date thereof Jan 14/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Fredericks Road

18 (a) Funeral director John C. Moran
(b) Address 3000 E Baltimore St

19 (a) (b)
(Date received) (Registrar)

JAN 13 1947

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 1947 at 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 26 1946 to Jan 11 1947 and that I last saw h[illegible] alive on Jan 11 1947

Immediate cause of death: My records Department

Due to: Arteriosclerosis — Duration: Since Sept 1946

Due to — Duration: 3 Years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature [illegible] M.D.

Address 2818 Pt. Road Date signed 1/11/47

X

17452

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13 B

G47452 Registered No.

Type the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland 141 Willard Street
(b) Street address Payson & Fayette Sts.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 141 Willard Street
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

**3 (a) FULL NAME** Miss Edna Austin EDNA AUSTIN

3 (b) If veteran, name war ******
3 (c) Social Security Account No. None.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife Single
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/24/1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 4 | 18 | hr. min. |

9. Birthplace Church Hill Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Austin
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma Jones
15. Birthplace Maryland

16 (a) Informant Mr. John Lerch
(b) Address 141 Willard Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 13 Jan 47 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore, Maryland

18 (a) Funeral director R. B. Tippett & Son
(b) Address 1300 Eutaw Place...17

JAN 13 1947 (Registrar) Hunter Jos. Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 11 1947, at 3:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1947 to Jan 11 1947, and that I last saw her alive on Jan 10 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral hemorrhage accident? | |
| Due to hypertension & arteriosclerosis | |
| Due to | |
| Other Conditions Pul. Tuberculosis & Diabetes | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William F. Carey, M.D.
M. D.
Address Bon Secours Hosp. Date signed 1/10/47

VS 150

83a

17453

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47453
Registered No.

46B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 months 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 Years

17 13

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 767 George St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country No

3 (a) FULL NAME
Matilda Durant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charles Durant

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-9-1880

8. AGE: Years 67 | Months 9 | Days 1 | If less than one day hr. min.

9. Birthplace Sumter Co. S. C.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Jesse Durant
13. Birthplace Ellio[illegible] S. C.

MOTHER
14. Maiden Name Amanda
15. Birthplace S. C.

16 (a) Informant Marion Bridgett
(b) Address 767 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 14, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Wm. Peter P. Williams
(b) Address 322 N. Schroeder St.

JAN 13 1947 (b) [illegible] Wm. Peter Williams, MD
(Date received by registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-10 1947, at 2:00A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7- 1946 to 1-10 1947
and that I last saw her alive on 1-10 1947

Immediate cause of death: Pyloric Obstruction of Stomach — Duration

Due to: Carcinoma of Pyloris

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature D. I. B. Higgins / Tmh MD

Address 1514 Dunbar Vt. Date signed 1/10/47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G17454

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G17454

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10A
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3113 Northway Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ERNEST H. BAYOR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18-1889

8. AGE: Years 57 | Months 4 | Days 24 | If less than one day hr. min.

9. Birthplace Budapest Hungary (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mrs. Elizabeth Bayor
(b) Address 3113 Northway drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-14-47 (month) (day) (year)
(c) Cemetery or crematory Moreland
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

JAN 13 1947 (Date received) (b) Harry [illegible] Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/11/47 19 , at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Weis, Medical Examiner M.D.
Date signed 1/11/47

VS 151

G47455

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1/31a

G47455 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3114 Rueckert Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3114 Rueckert Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Daisy A. Hiss

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F. | W. | Widowed |

6 (b) Name of husband or wife Hanibal C. Hiss
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 5 | 18 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER 12. Name Daniel Barr
13. Birthplace Md.

MOTHER 14. Maiden Name Celeste Langville
15. Birthplace Md.

16 (a) Informant Mrs. Marshall
(b) Address 32 Wheeling Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/13/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

JAN 13 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan. 10, 1947, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1946 to Jan 10 1947.
and that I last saw h[illegible] alive on Jan 9 1947.

Immediate cause of death Coronary Embolism — Duration 1 hr

Due to Mitral Regurgitation, Hypertension, Arteriosclerosis — Duration 40 days 40 days

Due to Chronic Interstitial Nephritis — Duration 40 days

Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T P A Stevens M. D.
Address 2878 Harford Rd. Date signed 1-11-47

X

Please write in ink. Every item of information must be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47456

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 54B

G47456 Registered No.

Please write the cause of death clearly and legibly. Physicians: please write correct age in especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 578 S Durham st.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore 31 (If outside city or town limits, write RURAL and give town)
(d) Street No. 578 S Durham st (If rural give location)
(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** Thomas Wagner

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-3427

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6-1913.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 34 | 6 | 6 | hr. min. |

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Time Keeper
11. Industry or business Lord Baltimore Hotel

FATHER
12. Name John Wagner
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Rezulak
15. Birthplace Baltimore Md

16 (a) Informant John Wagner
(b) Address 578 S Durham st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-12-47 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore Md

18 (a) Funeral director George A Weber
(b) Address 705 S Ann Street

(a) Date received by registrar JAN 13 1947 (b) Registrar Hamilton Williams M.D.

VS 8

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 11th 1947, at 6.03 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 18 1946 to Jan 11 1947 and that I last saw h— alive on Jan 11 1947.

| Immediate cause of death | Duration |
|---|---|
| Edema of lungs & cardiac insufficiency | 2 days |
| Due to Tumor of brain (left temporal lobe) | 5 weeks |
| Due to | |
| Other Conditions Paralysis right side. (Include pregnancy within 3 months of death) | 5 weeks |

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John V. Feaster M.D.
Address 1802 Eastern Ave Date signed 1-12-47

G47457

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

Registered No. G47457

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1714 W Lanvale
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs.) mos., or days) 30

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 W Lanvale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Weaver

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/15/1874

8. AGE: Years 72 | Months 3 | Days 24 | If less than one day hr. min.

9. Birthplace Virginia (town, county, and state)
10. Usual Occupation Retired
11. Industry or business R-R. Worker

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Eliza Hayes
(b) Address 3309 Fairfield Rd.

17 (a) Burial (b) Date thereof 1-13-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaiah L Brown & Son
(b) Address 108 W Montgomery St

19 JAN 13 1947 Huntington Willi[illegible] M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1947, at 12 noon M

21. I certify that death occurred on the date above stated, that I attended deceased from 12/4/46 to 1/9 1947.
and that I last saw h[illegible] alive on 1/9 1947.

Immediate cause of death — Duration

Cerebral Hemorrhage — 4 days
Due to Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. McAllister M.D.
Address 4 E. Lanvale Date signed 1/13/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

VS 150

G47458

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47458 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2335 Collington
(c) Hospital or institution:
1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland County
(b) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 233 S. Collington (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Michael ~~Berdych~~ BERDych

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 80 | Months 11 | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name —
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Adam

(b) Address 233 S. Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-47 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Balto. Co.

18 (a) Funeral director Wm. J. Fialkowski

(b) Address 2007 Eastern Ave

19 (a) (Date rec'd by registrar) (b) Certificate for Williams, M.D.

JAN 13 1941

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 1 | 11 | 47 19 , at 5:55 PM

**21.** I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Renal

Due to

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R. Weir M.D.
Medical Examiner.

Date signed 1/13/47

X

G47459

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1318

G47459 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2715 E. Madison St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2715 E. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN THOMAS BAUR (Ba uer)

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-1616

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| male | white | widowed |

6 (b) Name of husband or wife Laura Lingelback
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 30, 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 2 | 8 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation ratired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant John Wilhelm - grandson
(b) Address 2715 E. Madison St.

17 (a) Burial (b) Date thereof 1/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave.& Rose St. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) [illegible] JAN 13 1947 [illegible]

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8 1947 at 4 pm M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1947 to Jan. 19
and that I last saw him alive on Jan 8 1947

Immediate cause of death Acute-
Cardiac Dilatation

Duration: 1 day

Due to Hypertension Heart

Due to Disease

Other Conditions Chronic Nephritis

7 mo

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C H Meyer M. D.
Address 520 E 33rd Date signed 1/10/47

X

There will be no charge for information given or certificate supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47460 — BALTIMORE CITY HEALTH DEPARTMENT — G47460

# CERTIFICATE OF DEATH 183

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1733 Lancaster St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** CLIFFORD N. BALL

3 (b) If veteran, name war: World 2

3 (c) Social Security Account No. 105-16-3734

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife: Jean

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Jan. 24 1908

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 38 ~~39~~ | 11 | 17 18 | ____ hr. ____ min. |

9. Birthplace: New York N.Y.
(Town, county, and state)

10. Usual Occupation: Clerk

11. Industry or business

FATHER
12. Name: Howard Ball
13. Birthplace: Albany Co. N.Y.

MOTHER
14. Maiden Name: Emma Nankivell
15. Birthplace: Millerstown Pa.

16 (a) Informant: Mrs. A.B. Porter
(b) Address: 3516-16 34th St. Astoria L.I.31

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/13/47 (month) (day) (year)
(c) Cemetery or crematory
Location: Millerstown Pa.

18 (a) Funeral director: William J. Tickner & Sons
(b) Address: North & Pennsylvania Aves

19 (a) ____ (b) ____
(Signature of registrar)

JAN 13 1947

VS 131

## MEDICAL CERTIFICATION

20. DATE OF DEATH: JAN. 11th 1947, at 10 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/11/47 at 9 30 P. M. 2/3
(b) Where did injury occur? Ft. at Fell ST.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Found in the Harbor.

23. Signature: George L. Merrill M.D.
Medical Examiner.
Date signed 1/13/47

X

G47461

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G47461 Registered No. 100 B

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N. Carlin St
(c) Hospital or institution: St. Josepha Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 54

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1524 Byrd St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John W. Gurley

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-1852

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Florence Coleman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 4, 1892

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 59 | 3 | 8 | hr. min. |

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Nat. B. & S. Co.

FATHER
12. Name John W. Gurley
13. Birthplace Va.

MOTHER
14. Maiden Name Eddie Clarke
15. Birthplace Md.

16 (a) Informant Family
(b) Address 1524 Byrd St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 1-15-47 (month) (day) (year)
(c) Cemetery or crematory Cedar Grove
Location Brooklyn Md.

18 (a) Funeral director J. W. Gurley
(b) Address 132 S. Paca St.

19 (a) (Date rec'd by registrar) (b) Wilmington, Del.

JAN 13 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/12/47 19 5:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11/47 19 to 1/12/47 19, and that I last saw him alive on 1/11/47 19

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Pulmonary Embolus | |
| Due to Phlebitis of left arm | |
| Other Conditions Phlebothrombosis of Both Legs | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address St. Josephs Hosp. Date signed 1/12/47 M. D.

G47462 ✓ G47462

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1429 Battery Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Peter J. Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | M |

6 (b) Name of husband or wife Amelia V. Joyce

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1913

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 33 | 6 | 12 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Stevedore

11. Industry or business Jarka Corp

FATHER
12. Name Julius Green
13. Birthplace Russia

MOTHER
14. Maiden Name Mary Bnikulak
15. Birthplace Russia

16 (a) Informant Family
(b) Address 1429 Battery

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 1-14-47 (month) (day) (year)
(c) Cemetery or crematory Russian Orth.
Location Rome Annapolis Co

18 (a) Funeral director L. W. Conely
(b) Address 130 E. Fayette Baltimore, Md

19 (a) JAN 13 1947 (b) Registrar
Date received by registrar

VS 151

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** January 9, 1947, at 7:45 P.M.

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Spontaneous cerebral hemorrhage
Pulmonary edema
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature G. Merrill M.D.
Medical Examiner.
Date signed 1/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G47463

G47463

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 360 E Mohawk Ave
(c) Hospital or institution: Anderson Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 3700 N Charles St (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Mary Graham Bashor

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: none
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April-15-1867

8. AGE: Years 79 | Months 8 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Thos. C. Bashor
13. Birthplace Penna.

MOTHER
14. Maiden Name Emily A. Hedge
15. Birthplace Balto. Md.

16 (a) Informant Thos. T. Hedge (uncle)
(b) Address Owings Mills Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-14-47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore

18 (a) Funeral director Stewart Mortuary
(b) Address 108 W Lanvale St.

19 (a) JAN 13 1947 (Date Rec'd by Registrar) Thos. J. Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 1947, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29 1946 to Jan 11 1947, and that I last saw her alive on Jan 6 1947

Immediate cause of death: Cerebral Vascular accident — Duration: 5 months unknown

Due to: Arteriosclerosis

Due to: —

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Francis W Gluck M. D.
Address 715 Park Ave Date signed 1/13/47

VS 150

AB- 101523 G47464

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13 12 G12464

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7mos. 16days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 S. Lakewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Delores (Dembeck) Dembeck

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23- 1915

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 31 | 1 | 17 | hr. min. |

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name August
13. Birthplace Poland

MOTHER
14. Maiden Name Martha Krupske or Krupske
15. Birthplace Poland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 1/14/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Eastern Ave Rd.

18 (a) Funeral director John J. Duda
(b) Address 2849 Hudson St.

19 (a) (b) By registrar Registrar

JAN 13 1947
VS 150

**MEDICAL CERTIFICATION** AMC

20. DATE OF DEATH Jan. 10- 1947, at 10.45M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-24 1946 to 1-10- 1947 and that I last saw h[illegible] alive on 1-10- 1947

| Immediate cause of death | Duration |
|---|---|
| Enlargement Intercranial, for Advanced | 22 Mos. |
| Due to | |
| Due to | |
| Other Conditions Hx Laryngitis, Hx. Enteritis. | 4 Mos. |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not Done

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Hunt M. D.
Address Balt. City Hosp. Date signed 1-10-47

X

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G47465

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G47465
Registered No.

# CERTIFICATE OF DEATH 51B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 23 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Suite
3 (b) If veteran, name war
3 (c) Social Security Account No. 219-20-3376

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | ? | ? | hr. min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Peter Suite
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Byers
15. Birthplace Md.

16 (a) Informant D. Barnard
(b) Address Westminster, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-47 (month) (day) (year)
(c) Cemetery or crematory Pipe Creek Cem.
Location Near New Windsor, Md.

18 (a) Funeral director D. Barnard & Son
(b) Address Westminster, Md.

19 (a) JAN 13 1947 Huntington Williams, M.D. Registrar
(b) Date received JAN 13 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/12 1947, at 4:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/19 1946 to 1/12 1947 and that I last saw h.... alive on 1/12/47 19....

| Immediate cause of death | Duration |
|---|---|
| | |
| Due to Carcinoma of Prostate | |
| Due to | |
| Other Conditions Congestion Pneumonia Lung Abscess | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Negative

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Rosen M. D.
Address Sinai Hosp. Balto. Date signed 1/14/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G47466F BC# 42954 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G47466
Tel. 106495 CERTIFICATE OF DEATH 181 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitlals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 1 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 312 Pinewood Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
2 days name country

3 (a) FULL NAME Paul Stephen Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9th 1942

8. AGE: Years 5 | Months 0 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Paul Edward Stephen Sr.
13. Birthplace Maryland

MOTHER
14. Maiden Name Florence Williams
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave

17 (a) Burial (b) Date thereof 1-14-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Kirkwood Cemetery
Location Westminster, Md.

18 (a) Funeral director H. Bankard & Son
(b) Address Westminster, Maryland

19 (a) JAN 13 1947 Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12/ 19 47, at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/29/ 19 46. to Jan. 12 19 47, and that I last saw h.r. alive on Jan. 12th 19 47

| | Duration |
|---|---|
| Immediate cause of death: Multiple pulmonary infarcts of the bronchus | 9 |
| Due to: 30 burns (50% of body) | 7 wks. |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident Baltimore Co.
(b) Date of occurrence 11/29/46 at ? M
(c) Where did injury occur? 312 Pinewood Road
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No.
(Specify type of place)
(e) Means of injury Burned when gasoline ignited
23. Signature Wm. E. Hughes M. D.
Address Balto City Hosp. Date signed Jan 13 '47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 150

For Dr. Wm. S. Helfrich by Howard K. Mueller M. D.
This certificate subject to the approval of Medical Examiner. X

G47467 BALTIMORE CITY HEALTH DEPARTMENT ✓ G47467
Registered No.

# CERTIFICATE OF DEATH 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4502 Woodlea Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4502 Woodlea Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emily Roberto

3 (b) If veteran, name war 40
3 (c) Social Security Account No. no

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Charles N.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1871

8. AGE: Years 75 | Months 10 | Days 3 | If less than one day hr. min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER 12. Name John Bassett
13. Birthplace England

MOTHER 14. Maiden Name Matilda Dunn
15. Birthplace England

16 (a) Informant Frank Roberto
(b) Address 4502 Woodlea Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/14/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Fleetland Rd.

18 (a) Funeral director M. V. E. Diggs's Sons
Address Lombard & Ann Sts.

JAN 13 1947 (b)
(Date rec'd by registrar) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 10 1947 at 6:25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to Jan. 1 1947 and that I last saw her alive on 10 Jan. 1947

Immediate cause of death Uremia — Duration 1 wk.

Due to Arteriosclerotic cardio-vascular-renal disease. — 4 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: —
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wm. H. Kammler, Jr. M.D.
Address 501 Sheridan Ave. Date signed 13 Jan. 47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47468

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G47468

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3038 Greenmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Elvestus Wheeler.

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male. | White. | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-19-1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 10 | 24 | hr. min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Gardener
11. Industry or business

FATHER
12. Name Aquilla Wheeler
13. Birthplace Prince Geo. Co. Md.

MOTHER
14. Maiden Name Elizabeth Porter
15. Birthplace Md

16 (a) Informant Friends.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/16/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St

(a) JAN 14 1947 (Date received by Registrar) (b) Huntington Williams M.D.

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH Jan 13 1947, at 2.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1947 to Jan 13 1947, and that I last saw him alive on Jan 3 19 47

Immediate cause of death Basilar fracture

| | Duration |
|---|---|
| Due to Shock | |
| Due to Comp. occlusion? | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin Shuard M. D.
Address JHH Date signed 1-13-47

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

VS 150

X

47469

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 96

G47469 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd Calvert St.
(c) Hospital or institution: Union Mem Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 E MT VERNON PLACE (If rural give location)
(e) Citizen of foreign country? N.D (Yes or No)
If yes, name country

**3 (a) FULL NAME** MAY GARRETSON EVANS

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| N | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | S |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT 28 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 2 | 14 | hr. min. |

9. Birthplace BALTIMORE, MD (Town, county, and state)
10. Usual Occupation REPORTER - RETIRED
11. Industry or business NEWSPAPER

FATHER
12. Name HENRY EVANS
13. Birthplace BALTIMORE, MD

MOTHER
14. Maiden Name MARY GARRETSON
15. Birthplace MARYLAND

16 (a) Informant Henry R. Evans
(b) Address Mother on Apts 40th & Beech Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/14/47 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Washington D.C.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

JAN 14 1947 (Date received by registrar) Huntington Williams M.D. (Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH JAN 12 1947 at 10 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 4 1947 to JAN 12 1947 and that I last saw him alive on 12 JAN 1947.

Immediate cause of death: Arteriosclerotic Heart Disease. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: NONE

Was autopsy performed? Answer Yes or No. Were findings of Post Mortem used in completing the Medical Certification? Answer Yes or No.

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph C. Presti, M.D.
Address Union Mem Hosp. Date signed JAN 12, 1947 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

VS 150

937

G17470 wpa
639 - Carey st

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G17470 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 839 W. Franklin st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 90 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 839 W. Franklin st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Smith.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4-8-1848

8. AGE: Years 98 | Months 9 | Days 3 | If less than one day ____hr. ____min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Labrarer

11. Industry or business

FATHER
12. Name Silas Smith
13. Birthplace Va

MOTHER
14. Maiden Name Francis ?
15. Birthplace Va

16 (a) Informant Mrs Cassie Weathers

(b) Address 1006 Cambridge st Phila. Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location Baltimore Md

18 (a) Funeral director Williams & Jackson

(b) Address 916 Pennsylvania ave

19 (Signature and address of local registrar) JAN 14 1947 Williamsport, Md.

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 11, 1947 at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6-1947, to 1-11-1947, and that I last saw him alive on 1-10-1947

Immediate cause of death: (a) Myocarditis — Duration: 1 year

Due to: (b) —

Due to: (c) —

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature John E. J. Campbell M. D.

Address 639 N. Carey Date signed 1-13-47

V S 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47471

BALTIMORE CITY HEALTH DEPARTMENT 1243 ✓ G47471

# CERTIFICATE OF DEATH

Registered No.

Brought from Baltimore City Jail

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Mos
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Harry Sacks.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 47 | | | hr. min. |

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Loc Johns Hopkins Medical School JAN 13 1947
Commissioner of Health

18 (a) Funeral director
(b) Address

19 JAN 14 1947 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan. 2, 1947 at 8:15 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH a Cirrhosis of Liver
Ruptured Oesophageal varices
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 1/2/47

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47472

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

937

G47472 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City 51
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 N Ada (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LUKE RAY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 68 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 13 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 14 1947 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2/47 19 , at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 1/3/47

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G47473

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1702

G47473
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:** Baltimore
(a) State Md (b) County Roseville
(c) City or town Roseville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Labor Camp
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Howard C. CRIDDLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 45 | | | hr. min. |

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 13 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 14 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan. 8 1947, at 9:35 P.M.

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Contusion of brain
Subarachnoid hemorrhage of brain
Due to Compound fracture rt. tibia & fibula
Fractured pelvis
Other Conditions Fractured ribs
Terminal bronchopneumonia
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-20-46 at 7:10 P.M. Balto. Co.
(b) Where did injury occur? Highway on Rt. 40 near Martin
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Pedestrian struck by auto

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 1/4/47

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47474

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G47474 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Lader ave
(c) Hospital or institution: West Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 2-16
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4730 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph BAPER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 51 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Cutter

11. Industry or business

FATHER 12. Name unknown

13. Birthplace Russia

MOTHER 14. Maiden Name unknown

15. Birthplace Russia

16 (a) Informant Anna Bader

(b) Address 4730 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-47 (month) (day) (year)

(c) Cemetery or crematory

Location Herget & Herring Lem

18 (a) Funeral director Jack Lentz Inc

(b) Address 1439 E Biddle St

JAN 14 1947 (b) Registrar Washington, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 13 1947 at 8 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 10 1947 to JAN 13 1947, and that I last saw him alive on JAN 12 1947.

Immediate cause of death CEREBROVASCULAR ACCIDENT — Duration

Due to HYPERTENSIVE & ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Gumbrecht Jr

Address 3706 Rosedale Rd Date signed 1/13/47 M. D.

VS 150

X

G47475

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

G47475 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument H
(c) Hospital or institution Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
City or town Balto (If outside city or town limits write RURAL and give town)
(d) Street No. 2414 E Balto St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Yetta Singer

3 (b) If veteran, name war —
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | W |

6 (b) Name of husband or wife Louis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hospt Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-14-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pulaski Hwy & Hamilton Ave
18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St
19 (a) JAN 14 1947 (Date rec'd by registrar) Huntington Williams
(b)

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Jan 13 1947, at 12:42 M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec 22, 1946 to Jan 13 1947, and that I last saw her alive on Jan 13 1947

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure | |
| Due to Arteriosclerotic heart disease | |
| Due to | |
| Other Conditions Hypostatic pneumonia (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23.** Signature Sidney Green M. D.
Address Sinai Hospital Date signed 1/14/47

VS 150

G47476 BC# D47905

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

107

Registered No. G47476

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mos.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 Poplar Grove
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** - Michael B. Weston

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | S |

6 (b) Name of husband or wife 0
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-22-46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 7 | 22 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name George H. Weston
13. Birthplace Deltaville, Va.

MOTHER
14. Maiden Name Dorothy Goldsborough
15. Birthplace Baltimore, Md.

16 (a) Informant Dorothy Brundate Weston
(b) Address 1325 Poplar Grove

17 (a) Burial (b) Date thereof Jan. 15, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Md

18 (a) Funeral director Mr. & Mrs. John W. Tempel Sons
(b) Address 5311 Edmondson Ave

19 (a) [illegible] (b)
Registered by (Signature) Registrar

JAN 14 1947

V S 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** January 13 1947 at 9:05 AM

**21.** I certify that death occurred on the date above stated; that I attended deceased from 1/10 1947 to 1/13 1947 and that I last saw h. i. alive on 1/13 1947.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Lung tuberculosis, bronchiectasis & bronchopneumonia | 5 days |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature Wm G. Green M. D.
Address Sydenham Hosp Date signed 1/13/47

X

Please write plainly, with unfading ink. Physicians: please write the causes of death clearly and legibly. Any item of information known or obtainable from the attendant, relatives, or other sources should be supplied. The correct age is especially important.

G47477

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 92B

G47477 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 823 W Lombard St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 823 W Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Arthur L. Payne (Williams)

3 (b) If veteran, name war —

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | W | married |

6 (b) Name of husband or wife Carrie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | | | hr. min. |

9. Birthplace Charles County (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John William Payne
13. Birthplace Alexander Va.

MOTHER
14. Maiden Name Rose Morgan
15. Birthplace St Mary County

16 (a) Informant Carrie Payne
(b) Address 823 W Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location Annold County

18 (a) Funeral director Joseph Kaminskas Jr
(b) Address 604 Washington Blvd

19 (a) JAN 14 1947 (b) [illegible] Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13 1947 at 07A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1946 to Jan 13 1947 and that I last saw h[illegible] alive on Jan 12 1947

| Immediate cause of death | Duration |
|---|---|
| Acute Dilatation of Heart | 2 days |
| Due to: Chronic Nitrone | |
| Due to: Hypertension Varicose Veins | Indefy |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. K. Carstens M. D.
Address 1644 Hanover Date signed 1/14/47

VS 150

X

C17478

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Register No. C17478

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 30 W Cross
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 30 W. Cross St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** James H. K. Thomas

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Married |

6 (b) Name of husband or wife: Florence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 78 | | | hr. min. |

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Barber
11. Industry or business

FATHER 12. Name James Thomas
13. Birthplace md

MOTHER 14. Maiden Name Mary a —
15. Birthplace md

16 (a) Informant Florence Thomas
(b) Address 30 W. cross St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 16-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director James A Sayes
(b) Address 1442 W Pratt St

19 (a) JAN 14 1947 (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 12 1947 at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1946 to Jan 12 1947, and that I last saw him alive on Jan 11 1947.

Immediate cause of death Chronic Hypertensive Cardiac Disease — Duration about 1 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature John K. Haines M. D.
Address 507 W Lanvale St Date signed 1/13/47

VS 150

G17479

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

Registered No. G17479

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1711 McKean
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 Mc. Kean
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Carrie White

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| — | — |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | Widow |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | | | hr. min. |

9. Birthplace Cal. Co. Md
(Town, county, and state)
10. Usual Occupation maid
11. Industry or business

FATHER
12. Name Fletcher Dixon
13. Birthplace Md

MOTHER
14. Maiden Name Anna Lewis
15. Birthplace Md

16 (a) Informant David White
(b) Address 1711 McKean

17 (a) Burial (b) Date thereof Jan 15-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Brooks Chapel
Location Cal. Co. Md

18 (a) Funeral director James A. Sharp
(b) Address 1454 Eutaw Place

19 (a) JAN 14 1947
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 12 1947 at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15 1946 to 1-12 1947, and that I last saw h.e alive on 1-11 1947

Immediate cause of death — Duration

| | |
|---|---|
| Cerebral Hemorrhage | 7 days |
| Due to — | |
| Due to — | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Douglas Stuppert M. D.
Address 604 N. Eutaw Date signed 1-14-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G17480

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 B

Registered No. G17480

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 745 W. Mulberry
(c) Hospital or institution: 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 745 W. Mulberry
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Blanche Sweeting

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Colored | Married |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 18 1893

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | 8 | 22 | hr. min. |

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name John Russell
13. Birthplace md

MOTHER
14. Maiden Name Martha Galloway
15. Birthplace md

16 (a) Informant George Hopkins
(b) Address 745 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 14-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A. Dayer
(b) Address 42 W. Hill St

19 (a) JAN 14 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 10 1947 at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/9/47 19 , to 1/10/47 and that I last saw h alive on 1/10/47

Immediate cause of death: Pneumonia of the stomach — Duration: 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Lee Ellis M. D.

Address 92 Mosher Date signed 1/14/47

VS 190

G47481

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 939

Registered No. G47481

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2945 Walbrook Ave.
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County 6
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2945 Walbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** H. ALBERT RAYCOB

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | 705-05-6799 |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Viola M. Raycob
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 5 | 3 | hr. min. |

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Sgt. Police - B. & O. R. R.
11. Industry or business

FATHER
12. Name Henry A. Raycob
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa J. King
15. Birthplace Balto. Co., Md.

16 (a) Informant Mrs. Viola M. Raycob
(b) Address 2945 Walbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JAN 14 1947 (b) Huntington Williams M.D. Registrar
(Date received by Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11, 1947 at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 2, 1938 to Jan. 11, 1947, and that I last saw h[illegible] alive on Jan. 11 1947.

| | Duration |
|---|---|
| Immediate cause of death Cardiac Failure | 24 hours |
| Due to Chronic Myocarditis | 6 years |
| + Chronic Cardiac Hypertrophy | 6 years |
| Due to Chronic Hypertension | 9 years |
| Other Conditions Partial hemiplegia | 9 year |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ~
(b) Date of occurrence ~ at ~ M
(c) Where did injury occur? ~
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ~ While at work? ~
(Specify type of place) ~
(e) Means of injury

23. Signature Francis M. Ogburn M. D.
Address 2701 4. Calvert St. Date signed Jan. 12, '47.

VS 150

X

G47482

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

469

Registered No. G47482

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5356 Reisterstown Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) lifers

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5356 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** THOMAS KREINER

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Mary Catherine Krein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 0 | 19 | hr. min. |

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Poultry Dealer
11. Industry or business

FATHER
12. Name John L. Kreiner
13. Birthplace Germany

MOTHER
14. Maiden Name Mary B. Weinheim
15. Birthplace Germany

16 (a) Informant Mr. Thomas F. Kreiner
(b) Address 3819 Colborne Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 14 1947 (Date rec'd by Registrar) Huntington Williams, M.D. (b) Address 1206 E. Preston St. Date signed 1/13/47

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12, 1947, at 1:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July, 1946 to Jan 12, 1947 and that I last saw h alive on 19

Immediate cause of death Carcinoma – Pancreas & Liver — Duration 6 mo.

Due to —

Due to

Other Conditions Arteriosclerotic Cardio-Vascular Disease — 6
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Joseph S. Bloom M.D.
Date signed 1/13/47

G47483

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 58C ✓

Registered No. G47483

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 728 Newington Ave.
(c) Hospital or institution:

13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 728 Newington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARTHA VIRGINIA STREET ✓

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Single |

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 9, 1923

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 23 | 10 | 3 | hr. min. |

9. Birthplace Norfolk, Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Clay B. Street
13. Birthplace Essex Co., Va.

MOTHER
14. Maiden Name Ida Woodall
15. Birthplace Balto.

16 (a) Informant Mr. Clay B. Street
(b) Address 728 Newington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JAN 14 1947 (Date rec'd by registrar) (b) [signature] Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12, 1947 at 6:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1941 to Jan 12 1947 and that I last saw h.e alive on Jan 11 1947

| Immediate cause of death | Duration |
|---|---|
| Rheumatic Fever | |
| Due to Rheumatic Carditis | |
| Due to Rheumatic Cardiovascular Disease | 6 yrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 331 Stratford Ave. Date signed 1-13-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47484

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 486

Registered No. G47484

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1207 Morling Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 Morling Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mattie A. Brown.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| — | — |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | white | widow. |

6 (b) Name of husband or wife Wm. L. Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7, 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 5 | 5 | hr. min. |

9. Birthplace Virginia.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. Haynes
13. Birthplace Va.

MOTHER
14. Maiden Name Mill Michael
15. Birthplace Va.

16 (a) Informant Margaret M. Witt
(b) Address 1207 Morling Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 15/47 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden Md.

18 (a) Funeral director Chenowith & Donovan
(b) Address 3615-17 Chestnut Ave

19 JUN 14 1947 Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** January 12, 1947, at 12 50 M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to Jan 12 1947.
and that I last saw h er alive on Jan 11 1947.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of Uterus | 2 |
| Generalized Carcinomatosis | |
| Due to | |
| Due to | |
| Other Conditions Arteriosclerosis C V D | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature Laurence J Shimanek M.D.
Address 3711 Foley Rd Date signed 6-13-47

Shimanek X

VS 150

G17485 OC# 066798 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G17485

# CERTIFICATE OF DEATH 157M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address E. Monument St.
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 3 hrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2133 E. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Thacker

3 (b) If veteran, name war (c) Social Security Account No.

4. Sex Male 5. Color or race Undetermined - W. 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/4/47

8. AGE: Years | Months | Days | If less than one day 3 hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wm. Thacker
13. Birthplace Hyden, Ky.

MOTHER 14. Maiden Name Lena Bolduemer
15. Birthplace London, Ky.

16 (a) Informant Mr. Wm. Thacker
(b) Address 2133 E. Fairmount Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Johns Hopkins Medical School JAN 13 1947
Location Commissioner of Health

18 (a) Funeral director
(b) Address

19 JAN 14 1947 (Date rec'd by Registrar) (Signature) Huntington Williams M.D. Registrar

VS 150

**MEDICAL CERTIFICATION** 2nd Dr

**20. DATE OF DEATH** Jan 4 1947, at

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1947 to Jan 4 1947 and that I last saw ... alive on Jan 4 1947

Immediate cause of death Asphyxia — Duration

Due to Congenital Absence of Reducers — Duration

Due to — Duration

Other Conditions Multiple congenital abnormalities — Duration
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Levine M. D.
Address Sinai Hospital Date signed

X

B.C.-6-67367

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1577

G17486

G17486

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address E. Monument St

(c) Hospital or institution: Sinai

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1hr

(e) Length of stay in Baltimore (yrs., mos., or days) 1hr

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md. (b) County

(c) City or town Baltimore - 5

(If outside city or town limits, write RURAL and give town)

(d) Street No. 944 N. Chester St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

**3 (a) FULL NAME** Baby Boy Parker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: W.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/8/47

8. AGE: Years: 1D. Months: Days: If less than one day: 1 hr. min.

9. Birthplace Balto., Md. (Town, County, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Harold Parker

13. Birthplace Balto., Md.

MOTHER

14. Maiden Name Ruth Simpson

15. Birthplace Balto., Md.

16 (a) Informant Ruth Parker

(b) Address 944 N. Chester St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical School JAN 13 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 JAN 14 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8, 1947, at 12:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 8 1947 to Jan 8 1947, and that I last saw him alive on Jan 8 1947

Immediate cause of death Asphyxia

Due to Congenital absence of brain.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Samuel Ayler M. D.

Address Sinai Hospital Date signed

G47487 BC# G67782 ✓ G47487

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 157E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Druhelund + Rayner 2d
(c) Hospital or institution: W. Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3614 Bay Pk.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Counse

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | W | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 2 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Paul Counse
13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Martha Boyd
15. Birthplace N. Carolina

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 13 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 14 1947 (Date rec'd by registrar) Huntington Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 9 1947 19 30, at 12 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1947 to Jan 9 1947 and that I last saw h[illegible] alive on Jan 9 1947.

| Immediate cause of death | Duration |
|---|---|
| Myocardial failure | |
| Due to Congenital Heart Disease | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Congenital Hr. disease

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph M. Keith M.D.
Address W. Balt. General Hospital Date signed Jan 10 '47

VS 150

G47488 P.L. G-67430

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 160a

✓ G47488 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 306 Rock St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy White

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Mall. | Black | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-6-47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 1 | hr. min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Wm. E White
13. Birthplace Md
MOTHER 14. Maiden Name Sally Minton
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Local Johns Hopkins Medical School JAN 13 1947

18 (a) Funeral director Commissioner of Health
(b) Address

JAN 14 1947 (Date rec'd by registrar) Huntington Williams M.D.

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH Jan. 6 1947, at 10.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1947 to Jan 6 1947 and that I last saw him alive on Jan 6 1947.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Prematurity, atelectasis, intracranial hemorrhage | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Barton Childs M. D.
Address Johns Hopkins Hosp. Date signed 1-9-47

VS 150

X

G17489 BC# P66628

BALTIMORE CITY HEALTH DEPARTMENT ✓ History # 402473

# CERTIFICATE OF DEATH

160a Registered No. G17489

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1600 Webster Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby girl Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 2, 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 7 | hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name Phyllis Murphy
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 13 1947
Commissioner of Health

18 (a) Funeral director
(b) Address

19 JAN 14 1947 (Date received by Registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 9 1947, at 2:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1947 to Jan 9 1947, and that I last saw her alive on Jan. 9 1947.

| Immediate cause of death | Duration |
|---|---|
| Prematurity | |
| Cerebral hemorrhage | |
| Due to ? etiology | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Russell Jordan M. D.
Address Johns Hopkins Hospital Date signed

VS 150

G17490 DC #-67331

BALTIMORE CITY HEALTH DEPARTMENT

History # 400385 ✓

# CERTIFICATE OF DEATH

159

Registered No. G17490

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2830 Matthews Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Washinger

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 4, 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 1 | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Arthur Washinger
13. Birthplace

MOTHER
14. Maiden Name Virginia Bosley
15. Birthplace West Virginia

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 13 1947

18 (a) Funeral director Commissioner of Health
(b) Address
JAN 14 1947 (Date rec'd by registrar) (c) Hunter Jon Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 5 1947, at 3:28 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 4 1947 to Jan 5 1947 and that I last saw her alive on Jan 5 1947

Immediate cause of death: Prematurity — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Russell Dolan
Address Johns Hopkins Hospital Date signed 1-6-47 M.D.

VS 150

X

G47191 Blood Centrifuge 67617

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

✓ G47191 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address St. Joseph's Hospital
(c) Hospital or institution: 1400 Caroline St 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 2

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3209 Alameda Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Frances Elizabeth McLeod

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/11/47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 2 | hr. min. |

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Thomas Donald McLeod
13. Birthplace Bloomfield N.J.

MOTHER 14. Maiden Name Marie Catherine Houchens
15. Birthplace Pittsburg Pa

16 (a) Informant Mother
(b) Address 3209 Alameda Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/14/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Staley Gaither Funeral Home
(b) Address 1818 Eutaw Place

19 JAN 14 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 13 Jan 1947 at 11:40 A M

**21.** I certify that death occurred on the date above stated, that I attended deceased from 11 Jan 1947 to 13 Jan 1947 and that I last saw h[illegible] alive on 13 Jan 1947.

| Immediate cause of death | Duration |
|---|---|
| a. Atelectasis | |
| Scleroderma | |
| Due to Prematurity | |
| 36 weeks - Cesarean | |
| Due to Section on Mother for Placenta Previa | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23.** Signature Thomas J. Nelson M.D.
Address St. Joseph's Hosp Date signed 13 Jan 47

X

VS 150

G17192

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓83a

Registered No. G17192

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2708 Overland Ave
(c) Hospital or institution: 7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2708 Overland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Addison Bond Boyd (Legis

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Late James Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) About 3 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 9 | 9 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER
12. Name Wm H Addison
13. Birthplace Md

MOTHER
14. Maiden Name Lucas —
15. Birthplace Md

16 (a) Informant Mrs Harvey Lowell
(b) Address 2708 Overland ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 15 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3501 Frederick ave

18 (a) Funeral director Henry H Wilhelm
(b) Address 4101 Edmondson ave

19 (a) JAN 14 1947 Registrar Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/7 1947 to 1/12 1947 and that I last saw her alive on 1/11 1947

| Immediate cause of death | Duration |
|---|---|
| CEREBRAL HEMORRHAGE | 24 hrs. |
| Due to CEREBRAL ARTERIOSCLEROSIS | ? |
| Due to | |
| Other Conditions SENILITY | |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 6331 Belair Rd Date signed 1/13/47 M.D.

VS 150

G47493

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47493 Registered No. 48a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1530 HOLLINS ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 55 4 6

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1530 HOLLINS ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** MARY NAOMI JACOB

3 (b) If veteran, name war

3 (c) Social Security Account 212-05-8845

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced WIDOW

6 (b) Name of husband or wife DEAD.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG 7 1891

8. AGE: Years 55 | Months 4 5 | Days 6 | If less than one day hr. min.

9. Birthplace BALTO (Town, county, and state)

10. Usual Occupation SALESLADY

11. Industry or business HOT DONUT SHOPP

FATHER 12. Name GEO. W. HOWSER

13. Birthplace BALTO

MOTHER 14. Maiden Name ANNETTA THOMAS

15. Birthplace BALTO

16 (a) Informant MRS IRMA ROACH

(b) Address 505 N. LONGWOOD ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1-16-47 (month) (day) (year)

(c) Cemetery or crematory LORRAINE PK.

Location DICKEYVILLE

18 (a) Funeral director GEO. H. LEIMBACH

(b) Address 520 N LYNDHURST ST

19 (a) [illegible] (b) [illegible]

JAN 14 1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 13 1947, at 11 M. A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-19 1945 to 1-13 1947, and that I last saw h[illegible] alive on Jan 10 1947

Immediate cause of death: (a) Hemorrhagic Shock — Duration 2 hrs

Due to: carcinoma cervix uteri

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Rosen M. D.

Address 206 S. Gilmor St. Date signed 1-13-47

X

G47494

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 52B

Registered No. G47494

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4212 Parkmont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 y
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 Light St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Robert L. Poulton

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Lilly D. Poulton |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 7, 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 0 | 5 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Blue Printer

11. Industry or business B & O R.R. Co.

FATHER
12. Name Robert A. Poulton
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Didehaver
15. Birthplace Maryland

16 (a) Informant Harold L. Poulton
(b) Address 1112 N. Kenwood Ave

17 (a) Burial (b) Date thereof 1/15/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Ulbrich Funeral Home
(b) Address 2108 Orleans St

19 (Signature and address of registrar) JAN 14 1947 Huntington Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1946 to Jan 12 1947
and that I last saw h alive on Jan 12 1947

| Immediate cause of death | Duration |
|---|---|
| (a) Carcinoma Bladder | 8 mo |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. L. Poulton M. D.
Address 3400 Edmondson Date signed 1/13/47

V S 150

C47495

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. C47495

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2533 E Monument
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2533 E Monument Av (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Katherine Klatt — Kleeberger

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Robt Klatt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 6-1865

8. AGE: Years 81 | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER 12. Name Dom Tenor

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Dom Tenor

MOTHER 15. Birthplace Germany

16 (a) Informant Mrs Katherine Klatt

(b) Address 2533 E Monument

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 14th (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem City

Location

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2008 Orleans St

JAN 14 1947 (Date rec'd by registrar)

(b) Huntington Mills Baltimore, Md.

V S 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** January 11 1947, at 3:50 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to Jan 11 1947, and that I last saw h[illegible] alive on Jan 11 1947.

| Immediate cause of death | Duration |
|---|---|
| Enterocolitis — Generalized | ? |
| Due to Chronic Nephritis | ? |
| Myocardial Degeneration | ? |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis F. Kleiner M. D.

Address 2623 E. Monument Date signed 1/14/47

H X

G47496

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. G47496

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Mt Royal & St Paul
(c) Hospital or institution: 11

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. St Paul Apts (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Marion C Foerstch

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | White | married |

6 (b) Name of husband or wife Wm P Foerstch

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 23 1902

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 44 | 4 | 19 | hr. min. |

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Buyer
11. Industry or business Hecht Co

FATHER
12. Name Marion Cole
13. Birthplace Md

MOTHER
14. Maiden Name Daisy Waldron
15. Birthplace Md

16 (a) Informant Wm P Foerstch
(b) Address St Paul Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 14. (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem City
Location

18 (a) Funeral director Gillis Funeral Home
(b) Address 2008 Eutaw St

19 (a) JAN 14 1947 (Date rec'd by registrar) (b) Registrar

V S 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Jan 12 1947 at 6 a M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1946 to Jan 12 1947 and that I last saw her alive on Jan 11 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary occlusion | few minutes |
| Due to arteriosclerosis | 2 yrs |
| Due to Chr. nephritis | 2 yrs. |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23. Signature** H. J. McDermott M. D.
Address 1136 Poplar Grove St Date signed 1/13/47

G47197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G47197

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address 49 E Hughes St

(c) Hospital or institution: V

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md (b) County

(c) City or town Balto City
(If outside city or town limits, write RURAL and give town)

(d) Street No. 49 E Hughes St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Malia Wormley

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | M |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 8 | 5 | hr. min. |

9. Birthplace Washington D. C
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER

12. Name Unknown

13. Birthplace

MOTHER

14. Maiden Name Flottie Johnson

15. Birthplace Md

16 (a) Informant Sophronia Johnson

(b) Address 49 Hughes St

17 (a) Burial (b) Date thereof 1-14-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A.R.C. Md

18 (a) Funeral director Isaac L Brown

(b) Address 1090 Montgomery St

19 (a) (b) Huntington Williams Mgr
(Signature of local registrar) Registrar

JAN 14 1947

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 1/11/1947, at 11:15 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec. 27 1946 to Jan. 11 1947 and that I last saw h. alive on Jan. 10 1947

| Immediate cause of death | Duration |
|---|---|
| Apoplexy | 4 days |
| Due to | |
| Due to Chronic Nephritis Stab Syphilis | 3 mos. |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

**23.** Signature Lincoln Shelton M. D.

Address 906 E. Eager St. Date signed 1/14/47

X

G47198

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. G47198

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4425 Parkmont Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4425 Parkmont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Alson Douglas

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Emma A. Douglas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1864

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | 1 2 | 11 | hr. min. |

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Smith Cox D. Douglas
13. Birthplace N.C.

MOTHER
14. Maiden Name Sophia Seely
15. Birthplace N.C.

16 (a) Informant Howard C. Douglas
(b) Address 4425 Parkmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 16/47 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto. Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 (Date received by registrar) JAN 14 1947 Hamilton Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 12, 1947 19 , at 10.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 16 1946, to Jan. 12 1947, and that I last saw h.m alive on Jan. 11 19 47.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemmorrhage | 10 days |
| Due to Arteriosclerosis | many yrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Wilkinson, M. D.
Address 5713 Bel Air Rd. Date signed 1-14-47

VS 130

G47499

BALTIMORE CITY HEALTH DEPARTMENT

AB-107536

# CERTIFICATE OF DEATH 8-3a

Registered No. G47499

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 76
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 S. Eaton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Reigle

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| -- | -- |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widowed |

6 (b) Name of husband or wife Edward (D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4- 187[illegible]

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 10 | 9 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name ? Robinson
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary ?
15. Birthplace Pa.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 16/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

JAN 14 1947 (Date rec'd by registrar) (b) [illegible]

V S 190

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 13- 1947, at 2.50PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-12 1947 to 1-13 1947, and that I last saw h er alive on 1-13 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebro-vascular accident | |
| Due to Senile dilatation aneurism | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W Doyle Waldron M. D.
Address B C H Date signed 1-13-47

X

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47500

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1939

Registered No. G47500

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State (b) County 11 D
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Plaza apartments (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** SARA E. DONOHO

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Fred Donoho
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) OCT 21, 1874

8. AGE: Years 72 | Months 2 | Days 22 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: House duties
11. Industry or business: —

FATHER
12. Name: John H. Strohmeyer
13. Birthplace: Balto

MOTHER
14. Maiden Name: Margaret Thompson
15. Birthplace: Balto

16 (a) Informant: Fred. Donoho
(b) Address: Plaza Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jany 15/47 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville Md

18 (a) Funeral director: John O'Donnell
(b) Address: 1900 Eastern Place

19 (a) Date: JAN 14 1947 (b) Signature: Washington Williams, Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 1/12 1947, at 8:30 PM

**21.** I certify that death occurred on the date above stated; that I attended deceased from 1/11 1947 to 1/12 1947 and that I last saw HER alive on 1/12 1947

| Immediate cause of death | Duration |
|---|---|
| CARDIAC FAILURE | 1 DAY |
| AURICULAR FIBRILLATION | |
| Due to HYPERTENSIVE CARDIO-VASCULAR DISEASE | |
| Due to | |
| Other Conditions EARY INTESTINAL OBSTRUCTION (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Charles N. Stewart, Jr. M. D.
Address: Md. Gen. Hosp. Date signed 1/12/47

VS 150

X

G47501

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1948

G47501 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution:
University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) —

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Harford
(c) City or town Bel Air Md (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 32 1005 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Nathan Johnson

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | C | S |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1912

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 34 | 6 | 1 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation —
11. Industry or business Revere Copper & Brass

FATHER
12. Name Vernon Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Carroll
15. Birthplace Md.

16 (a) Informant Nathan Johnson
(b) Address 1005 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/14/47 (month) (day) (year)
(c) Cemetery or crematory Sharp St.
Location Chase, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-512 N. Carrollton Ave

1-14-1947 (Date received by registrar) Wellington Williams, M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-11 1947, at 5 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9 1946 to 1-11 1947, and that I last saw him alive on 1-11 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardiac Failure | |
| Due to Rheumatic Cardiovascular Disease — Mitral Stenosis + | |
| Due to Insufficiency | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. L. Driggs M.D.
Address Bel Air, Md. Date signed 1-11-47

410 X

G47502

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

Registered No. G47502

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1922 E. Chase St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Sara Jennie Rehm

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | married |

6 (b) Name of husband or wife Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-27-1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 5 | 17 | hr. min. |

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Huston
13. Birthplace Z.

MOTHER
14. Maiden Name Catherine Smeltzenright.
15. Birthplace Holland

16 (a) Informant Friends.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 1-17-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Meadowridge
Location West Blvd

18 (a) Funeral director John C. Miller Jr.
(b) Address 2437 E. Oliver St.

19 (a) JAN 14 1947 [illegible] Md.

VS 150

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH Jan-13 1947 at 10.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-13 1947 to Jan-13 1947, and that I last saw h[illegible] alive on Jan 13 1947,

| | Duration |
|---|---|
| Immediate cause of death Pulmonary Edema | 1 day |
| Due to Cardiac Failure | 1 day |
| Due to Myocardial Infarction | 1 day |
| Other Conditions Hypertension | 3 |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Douglas Harrell M.D.
Address 5 Thurs Hopkins Hosp Date signed 1-14 1947

443

Hosp × 47

G47503

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 139a

G47503 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Howard & Madison St.
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Harford
(c) City or town Fork
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Gwenn Mc Cleary

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Thomas Mc Cleary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 21 1926

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 20 | ✓ | 22 | hr. min. |

9. Birthplace Shelby N. Carolina
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Thos. F. McCleary
(b) Address Hyde Md.

17 (a) Burial (b) Date thereof Jan 15-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Cem.
Location Towson Md.

18 (a) Funeral director Clarence E. Arthur
(b) Address Fork Md.

19 (a) JAN 14 1947 (b) Name of registrar Wilmington, Del.

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 1-12 1947, at 10½ P.M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 1-11 1947, to 1-12 1947, and that I last saw her alive on 1-12 1947.

Immediate cause of death Respiratory failure
Duration

Due to

Due to

Other Conditions due to acute pulmonary inflammatory disease
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: Generalized peritonitis

of autopsy: Same as above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Anesthetic accident
(b) Date of occurrence 10 PM 1-12 1947
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury Spinal anesthesia

23. Signature Carlton Bamfield M. D.
Address Md. Gen. Hosp. Date signed 1-12-47

VS 150

G47504

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 45 F

G47504 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3305 Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ANDREW HENRY BAUMGARTNER

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | 216-03-8541 |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Lottie W. Smith
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) May 3.1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 62 | 8 | 8 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation President
11. Industry or business Borden Ice Cream Co.

FATHER
12. Name Andrew Baumgartner
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elizabeth Geist
15. Birthplace Baltimore

16 (a) Informant Mrs. Lottie W. Baumgartner
(b) Address 3305 Guilford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 14. 1947 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Baltimore Md

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address North Ave. & Broadway.

19 (Date received by Registrar) JAN 14 1947 Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-11 1947 at 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1946 to 1-11 1947 and that I last saw h alive on 1-11 1947

Immediate cause of death Cancer of Tonsil — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F M Kruger M. D.
Address Sinai Hosp. Date signed 1-11-47

VS 150

146 X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47505

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G47505

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2838 Harford Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2838 Harford Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ALICE VIRGINIA SUDSBURG

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife William P. Sudsburg
6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) Feb. 22. 1856

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 10 | 21 | hr. min. |

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Martin Hanrahan
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellan Jordon
15. Birthplace Ireland

16 (a) Informant Mrs. Grace Gerhold (Daughter)
(b) Address 2838 Harford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 15. 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address North Ave. & Broadway

19 (a) JAN 14 1947 (Date rec'd by registrar) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12. 1947 at 3.30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9. 1947. to Jan 12. 1947. and that I last saw h[illegible] alive on Jan 12 1947.

| Immediate cause of death | Duration |
|---|---|
| Uraemia | 3 days |
| Due to (Heart Failure) | |
| Due to Arteriosclerosis | 10 yrs |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide X
(b) Date of occurrence X at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. E. Pinguement M. D.
Address 2858 Harford Ave. Date signed 1/13/47

4/22.1 X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C47506

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

Registered No. C47506

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 901 S. Streeper St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 S. Streeper St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** CATHERINE ROLL KLEIN

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Frank L. Klein
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar. 13. 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 10 | 0 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Samuel Jones
13. Birthplace Baltimore

MOTHER
14. Maiden Name Anna Reese
15. Birthplace Baltimore

16 (a) Informant Mrs. Edna Bryant
(b) Address 901 S. Streeper St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 194 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location Baltimore

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address Baltimore Md.

19 (a) JAN 14 1947 (Registered by registrar) Wellington Williams M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13. 1947 at 3.05 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Jan. 13 1947 and that I last saw her alive on Jan. 13 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | Unknown |
| Due to Essential Hypertension | Unknown |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation None
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the followings
(a) Accident, suicide or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. A. Rosenblatt M. D.
Address 3018 O'Donnell St Baltimore, Md. Date signed 1-13-47

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G47507

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 97

Registered No. G47507

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3700 Liberty Heights
(c) Hospital or institution: 15 11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3700 Liberty Heights (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** PAULINE DOBLER BAYNE

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Dashiel Bayne
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 20. 1860

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 86 | 0 | 22 | ....hr. ....min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jonathan Knight
13. Birthplace Penna.

MOTHER
14. Maiden Name Amelia Cecil
15. Birthplace Baltimore

16 (a) Informant Mrs. Wm. L. Evans (Daughter)
(b) Address 3700 Liberty Heights

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 16 1947 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Baltimore

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address Baltimore Md.

19 (a) JAN 14 1947 (Date rec'd by registrar) [illegible] Registrar, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12 1947 at 11.15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15th 1945 to Jan 12th 1947 and that I last saw her alive on Jan 12th 1947.

| Immediate cause of death | Duration |
|---|---|
| Hemorrhage | 1 day |
| Due to arteriosclerosis | 2 years |
| Due to senility | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. G. Poulton
Address 3906 Gwynnbrook Blvd Date signed 1/13/47

450.0 X

G47508

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1310

Registered No. G47508

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1955 Perlman Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1955 Perlman Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albin Scheski

3 (b) If veteran, name war 1st
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 31st - 1887

8. AGE: Years 59 | Months 9 | Days 11 | If less than one day hr. min.

9. Birthplace Md (Town, county and state)
10. Usual Occupation Office Of Supervisor
11. Industry or business Board Of Elections

FATHER
12. Name John Scheski
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Mrs Leahill
(b) Address 1955 Perlman Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 15th 1947 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Baltoleum
Location E North Ave Ext

18 (a) Funeral director Leo G. Cook
(b) Address 1701-03 No. Patterson Park ave

19 JAN 14 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11th 1947, at 1 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 30 Dec 1946 to 11 Jan 1947, and that I last saw h alive on 11 Jan 1947.

| | Duration |
|---|---|
| Immediate cause of death: Coronary thrombosis | 12 hrs |
| Due to: Cardio-Vascular-Renal disease | 7 |
| Due to: | |
| Other Conditions: — | |

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operations: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Silverfarb M. D.
Address 714 E. Preston Date signed 13 Jan 47

4301

X

G47509

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1111c

G47509 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 351 Yale Ave
(c) Hospital or institution: 20

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 351 Yale Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Catherine J Ronan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife John W

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 19 1861

8. AGE: Years 86 | Months 4 | Days 2d | If less than one day hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Thos Boland
13. Birthplace Ireland New York

MOTHER 14. Maiden Name Not Known
15. Birthplace "

16 (a) Informant Miss E. Ronan
(b) Address 351 Yale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-16-47 (month) (day) (year)

(c) Cemetery or crematory Catholic Cem
Location Balto Md

18 (a) Funeral director Geo A Daley
(b) Address Fulton & Fayette

JAN 14 1947 (Date received by Registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 13 1947 at 2 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to Jan 13 1947 and that I last saw h[illegible] alive on Jan 13 1947.

Immediate cause of death Hypostatic pneumonia — Duration

Due to Senility

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A H Crawford M. D.
Address 4704 Hood Ave Date signed 1/14/47

VS 150

X

G47510

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G47510

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: 1749 E. North Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days): None
(e) Length of stay in Baltimore (yrs., mos., or days): Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: Md. (b) County: City
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 1749 E. North Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Emil A. Hirsch

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: 215-05-4207

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age ——years

7. Birth date of deceased (mo., day, yr.): July 6th., 1896

8. AGE: Years: 50 Months: 6 Days: 7 If less than one day: ##### hr. ____ min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Chief Stockman

11. Industry or business: Printing Co.,

FATHER — 12. Name: Charles B. Hirsch
13. Birthplace: Germany

MOTHER — 14. Maiden Name: Petronilla Buck
15. Birthplace: Germany

16 (a) Informant: Miss. Catherine M. Hirsch
(b) Address: 1749 E. North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1/16/47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Road, Balto: Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19. JAN 14 1947 (Date rec'd by registrar) (b) Washington-Forrest Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 13, 1947; at ____ M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 Jan 1947 to 12 Jan 1947 and that I last saw him alive on 12 Jan 1947

Immediate cause of death: Cerebro-vascular Accident — Duration: 6 Days

Due to: Hypertensive Cardio-vascular disease — 5 years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Lee M. Zimmerman, M.D.
Address: 2050 Harford Rd. Date signed: 14 Jan. 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

448 X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47511 CWK-106581

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G47511

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 10-
(e) Length of stay in Baltimore (yrs., mos., or days) 12 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 Wyath Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Cooper (John O. Cooper)

3 (b) If veteran, name war

3 (c) Social Security Account No. 211-07-8519

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10-1912

8. AGE: Years 34 | Months 6 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation Taxi Driver

11. Industry or business

FATHER
12. Name Justice William Cooper
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Sarah Gilmer
15. Birthplace Pennsylvania

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 1-16-47 (month) (day) (year)
(c) Cemetery or crematory Shadeview Gen. & Shadeland, Pa
Location
18 (a) Funeral director J. L. McCauley
(b) Address 1500 S. Fort Rd.

19 (a) JAN 14 1947 (Registrar's signature) Registrar

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 1947, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 3 1946, to Jan. 13 1947, and that I last saw him alive on Jan. 13 1947.

Immediate cause of death: Pulmonary Tuberculosis, Far Advanced — Duration 3 yrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Refused

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Hunt M. D.
Address Balt City Hosp. Date signed 1-13-47

002

X

G47512

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G47512 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1222 Edison Hgy
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1222 Edison Hgy (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lillian Polley

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-16-7349

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Joseph Polley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9-1903

8. AGE: Years 43 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER — 12. Name John Schertle
13. Birthplace Germany

MOTHER — 14. Maiden Name Schuck
15. Birthplace Germany

16 (a) Informant Mrs Mary Schertle
(b) Address 1222 Edison Hgy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-47 (month) (day) (year)
(c) Cemetery or crematory Balto
Location Balto

18 (a) Funeral director [illegible] & Sons
(b) Address 3001 Eutaw Ave

19 (a) (Date rec'd by registrar) JAN 14 1947 (b) [illegible]

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14, 1947, at 9 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11 1947 to 1/14 1947. and that I last saw h[illegible] alive on 1/11 1947

Immediate cause of death — Duration

Coronary Thrombosis — 3 days

Due to ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold A. Gratt, M.D.

Address 6100 Harford Ave Date signed 1/13/47

4201 X

G47513

BALTIMORE CITY HEALTH DEPARTMENT X 46 M

# CERTIFICATE OF DEATH

Registered No. G47513

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Carroll
(c) City or town Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 6 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Margorie Dell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife David E. L. Dell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 7 | 8 | hr. min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Lawyer.
11. Industry or business

FATHER
12. Name Columbus Parker
13. Birthplace Md.

MOTHER
14. Maiden Name Tabithia Dell
15. Birthplace Md.

16 (a) Informant Mr. David Dell
(b) Address Westminster R.F.D. #6, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-16-47 (month) (day) (year)
(c) Cemetery or crematory Old Oakland Cem.
Location W. Oakland Mills, Md.

18 (a) Funeral director C. Harry Weer
(b) Address Sykesville, Md.

19 (Filed) JAN 14 1947 (Registrar) Westminster Mills, Md.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-14 1947, at 8:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5 1947 to 1-14 1947 and that I last saw h[illegible] alive on 1-14 1947.

Immediate cause of death Cardiac Standstill — Duration

Due to Hypertensive Arteriosclerotic Cardiovascular disease.

Due to Acute Fulminating bronchitis Pneumonia Lobular

Other Conditions Pyelitis Co. of R.K. Chest w. Liver

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. A. Shallenberger Jr. M. D.
Address University Hospital Date signed 1-14-47

42011 X

G47514 7485

BALTIMORE CITY HEALTH DEPARTMENT X 467

# CERTIFICATE OF DEATH

Registered No. G47514

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Florida (b) County.....
(c) City or town Lakeland, Route 1 (If outside city or town limits, write RURAL and give town)
(d) Street No..... (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

**3 (a) FULL NAME** Nellie Bay

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert C. Bay

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 2-9-77

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 11 - | 4 | ..... hr. ..... min. |

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Samuel Guyton

13. Birthplace Ohio

MOTHER 14. Maiden Name Nancy Yeazel

15. Birthplace Ohio

16 (a) Informant.....

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof JAN. 14, 1947 (month) (day) (year)

(c) Cemetery or crematory OAK GROVE

Location LAKELAND, FLA.

18 (a) Funeral director Williams Cook & Sons

(b) Address 1217 St. Paul St.

19 (a) Received by Registrar JAN 14 1947 (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-13- 1947 at 6.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5, 1947 to Jan 13 1947 and that I last saw her alive on Jan. 13 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral vascular accident | 48 hrs |
| Due to Hypertension | |
| Due to ..... | |
| Other Conditions Carcinoma of rectum | 2 mos |

(Include pregnancy within 3 months of death)

Date of operation [redacted]

Major findings of operation: Carcinoma of rectum

Was autopsy: Some

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Richard C. Cleary

Address Johns Hopkins Hosp. Date signed 1/14/47

VS 150

154 X

G47515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G47515

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5221 Denmore Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5221 Denmore Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: LOTTIE H. MATTHEWS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1869

8. AGE: Years 71 | Months 6 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Co., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Alexander Henson
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Bruce
15. Birthplace Md.

16 (a) Informant Mrs. Mildred Gambrill
(b) Address 5221 Denmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-47 (month) (day) (year)
(c) Cemetery or crematory St. Thomas Cem.
Location Randallstown, Balto. Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) JAN 14 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 11, 1947 at 9A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 31, 1946 to Jan. 11, 1947. and that I last saw her alive on Jan. 6, 1947.

| Immediate cause of death | Duration |
|---|---|
| Chronic myocarditis | |
| Due to | |
| Due to | |
| Other Conditions Arteriosclerosis viscero ptosis | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. R. Campbell, M. D.
Address 718 Dolphin St. Date signed 1-13-47

422.1 X

G47516

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47516
Registered No.

507918. 157E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Va (b) County
(c) City or town Woodford.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Robert Fritter

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-3-43

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 3 | 1 | 11 | hr. min. |

9. Birthplace Va (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Fritter
13. Birthplace Va.

MOTHER
14. Maiden Name Bessie Mitchell
15. Birthplace Va.

16 (a) Informant Rhonda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/14/47 (month) (day) (year)
(c) Cemetery or crematory Forest Lawn Cem.
Location Richmond, Va.

18 (a) Funeral director Wm. J. Tuckers Sons
(b) Address Mohr Aves.

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 14 1947

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH Jan 13 1947 at 11.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1947 to Jan 13 1947 and that I last saw him alive on Jan 13 1947.

| | Duration |
|---|---|
| Immediate cause of death Cardiac failure | 1 yr |
| Due to Congenital heart disease | Life |
| Due to | |
| Other Conditions Aortic stenosis Patent ductus arteriosus (Include pregnancy within 3 months of death) | |
| Date of operation 1/13/47 | |
| Major findings of operation Patent ductus arteriosus | |
| of autopsy Same | |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry E. Bahrs
Address Johns Hopkins Hosp. Date signed 1/14/47 M.D.

753.1

G47517

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 99

G47517

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution:
So. Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 ½

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 309 Sharp Street
(If rural give location)
(e) Citizen of foreign country? Nat (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Scott

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | S. |

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 48 | | | hr. min. |

9. Birthplace Nat Brown (Town, county, and state)

10. Usual Occupation Unemployed.

11. Industry or business

FATHER 12. Name Thomas Scott

13. Birthplace —

MOTHER 14. Maiden Name Diana —

15. Birthplace —

16 (a) Informant Self.

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Location Johns Hopkins Medical School JAN 14 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 JAN 14 1947 (Date rec'd by registrar) Huntington Williams M.D.

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan. 11, 1947 at 7:10 P.M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 11 1947 to Jan 11 1947 and that I last saw him alive on Jan 11, 1947.

| Immediate cause of death | Duration |
|---|---|
| Intestinal Obstruction | 7 hrs. |
| Due to Thrombosis Superior Mesenteric Artery | 7 hrs. |
| Due to | |
| Other Conditions | |

(Includes pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide 570.2
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23.** Signature Rocco L. Lafauto M. D.

Address So. Balto. Gen. Hosp. Date signed 1-13-47

VS 150

For R. J. Lubimoff, by Howard J. Malfetti, M.D.

G47518

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 82a

G47518 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 337 Lorraine Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 337 Lorraine Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** PATRICK J. McGINNIS

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| Spanish American | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | | | hr. min. |

9. Birthplace Texas, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John McGinnis
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine (?)
15. Birthplace

16 (a) Informant Mr. M.E. Murray
(b) Address 337 Lorraine Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/16/47 (month) (day) (year)
(c) Cemetery or crematory St. Josephs Cem
Location Texas, Md.

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVE & 22Nd

JAN 24 1947 (a) (b) Huntington Williams M.D. Registrar
(Date received) (Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 13 19 47, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9 1947, to Jan 13 1947, and that I last saw him alive on Jan 13 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | unknown |
| Due to Arteriosclerosis | unknown |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Isaac R. Greenbaum M.D.
Address 1923 N. Rutland Ave Date signed Jan 14

331 X

VS 150

G47519

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G47519

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address 6000 Belona Ave

(c) Hospital or institution: Edmondson Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1

(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 816 Winston Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

**3 (a) FULL NAME** William McKeown

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widow |

6 (b) Name of husband or wife Katherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 4 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 3 | 9 | hr. min. |

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER 12. Name Dennis McKeown

13. Birthplace Ireland

MOTHER 14. Maiden Name Sarah Cloyle

15. Birthplace Ireland

16 (a) Informant Margaret Moran

(b) Address 601 Belona Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 14/47 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Old Frederick Road

18 (a) Funeral director John A Moran

(b) Address 3600 E Baltimore St

JAN 15 1947 (b) Huntington Williams, M.D.

(Date received by local registrar)

V S 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 13 1947 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6-1947 to 1-13 1947, and that I last saw h. alive on 1-12 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Arteriosclerosis | 1 yr. |
| Due to Renal Arteriosclerosis | 10 yrs. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible] Thomas

Address 5814 York Rd Date signed 1-13-47 M.D.

4150 D

X

G47520

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G47520

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1951 W. Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1951 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Elizabeth Hanley

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1860

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 87 | | 12 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Owen Hanley
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine --------
15. Birthplace Md.

16 (a) Informant Miss Hattie Hunt (Niece)
(b) Address 1951 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 15/47 (month) (day) (year)
(c) Cemetery or crematory St. Joseph's
Location Texas, Md.

18 (a) Funeral director Harry A. Whistle
(b) Address 4101 Edmondson Ave.

19 (a) JAN 15 1947 (b) Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 13, 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1940 to Jan 13 1947 and that I last saw h[illegible] alive on Jan 13 1947.

Immediate cause of death: Coronary Embolism — Duration: 1 day
Due to: Myocardial Degeneration
Due to:
Other Conditions: Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Katzenberg M. D.
Address 1541 Medical Arts Bldg. Date signed 1/16/47

420.1 X

G47521

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 B

G47521 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 512 East 27th St. City 18 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Milton John Magarity

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-20-9065A

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Kate E. Magarity
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 4 1877

8. AGE: Years 69 | Months 2 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Machine Operator

11. Industry or business Md. Box Co.

FATHER — 12. Name Milton J.S. Magarity
13. Birthplace Maryland

MOTHER — 14. Maiden Name Eliza Wallace
15. Birthplace Maryland

16 (a) Informant Kate E. Magarity
(b) Address 512 East 27th St. City 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/47 (month) (day) (year)

(c) Cemetery or Crematory Asbury M.E. Church
Location Reisterstown Md

18 (a) Funeral director Sherwin Cook Inc
(b) Address 1217 St. Paul Street

19 JAN 15 1947 (Date received by Registrar) (b) Huntington Williams, M.D. (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13th 1947 12 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1947 to Jan 13 1947 and that I last saw him alive on Jan 12 1947

Immediate cause of death: Carcinoma of stomach with Metastasis to
Due to: pleura & lung — Duration: 1 yr?
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: Carcinoma of lung

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman M.D.
Address Union Memorial Hosp. Date signed Jan 13 47

VS 150

151 X

G17522 NGD 15739

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Register No. G17522

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10--8---21
(e) Length of stay in Baltimore (yrs., mos., or days) 34 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 North Bradford St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Delbert Fountain

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1869

8. AGE: Years 77 ? | Months 10 ? | Days 10 ? | If less than one day ____ hr. ____ min.

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Farming

FATHER
12. Name Bradley B. Fountain
13. Birthplace New York

MOTHER
14. Maiden Name Rebecca Crawford
15. Birthplace New York

16 (a) Informant Baltimore City Hospital Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 1/17/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 1212 St. Paul Street

19 (a) JAN 15 1947 Huntington Williamson, M.D.
(Date rec'd by Registrar)

V S 190

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 1947, at 7:15PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 22 1936, to Jan. 13 1947, and that I last saw him alive on Jan. 13 1947

| Immediate cause of death | Duration |
|---|---|
| Lobar Pneumonia, Lt Lung | 5 days |
| Bronchopneumonia, Rt Lung | 5 days |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.
Address City Hosp. Date signed 1/14/47

490 - X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47523

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G47523 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1803 N. Caroline St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 N. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** James F. Knighton

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Blanche E. Knighton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 0 | 24 | hr. min. |

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Retired Insurance Agent
11. Industry or business Insurance

FATHER
12. Name John T. Knighton
13. Birthplace Annapolis Md

MOTHER
14. Maiden Name Margaret A. Canty
15. Birthplace Baltimore Md

16 (a) Informant Blanche E. Knighton
(b) Address 1803 N. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-16-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Wm. Cook Son
(b) Address 207 St. Paul St.

19 (c) JAN 15 1947 (Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 13 1947, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1946 to Jan 13 1947 and that I last saw h[illegible] alive on Jan 13 1947

Immediate cause of death Cardiac Failure — Duration
Due to Diabetes Mel. —
Due to Chr Nephritis —
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. C. Mornings M. D.
Address 800 E North Ave Date signed 1/14/47

260 X

VS 150

G47524

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G47524

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 801 Gorsuch Ave
(c) Hospital or institution: 91
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 801 Gorsuch Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Robert Allen

3 (b) If veteran, name war

3 (c) Social Security Account No. 091-01-3496

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13th 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 9 | 0 | hr. min. |

9. Birthplace Phila. Pa. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name William W. Allen
13. Birthplace Phila. Pa.

MOTHER
14. Maiden Name Elizabeth S. Coane
15. Birthplace Phila. Pa.

16 (a) Informant Col. Charles Allen for
(b) Address 1910 Kalorama Rd Wash D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/47 (month) (day) (year)
(c) Cemetery or crematory Mahma
Location Baltimore Md

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) JAN 15 1947 (Date rec'd by registrar) (b) Number on Mortuary list

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13th 1947 at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1947 to Jan 13 1947 and that I last saw h in alive on Jan 12 1947

Immediate cause of death: Coronary thrombosis

| | Duration |
|---|---|
| | |
| Due to | |
| | |
| Due to | |

Other Conditions: Cerebro Arterio Sclerosis Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward J. Schenuit M. D.
Address 1307 S. Charles St Date signed 1/14/47

VS 150

4201 X

G47525

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1110a

G47525

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 726½ W. Saratoga Street (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country.....

**3 (a) FULL NAME** Gertrude Sullivan 45

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 15, 1901

8. AGE: Years 45 | Months 9 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace unknown (Town, county, and state)

10. Usual Occupation Hotel Maid

11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Beatrice Dunlap
(b) Address 670 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/16/47 (month) (day) (year)
(c) Cemetery ~~or Crematory~~ Mt. Calvary
Location Cedar Hill Md

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 JAN 15 1947 (Date received by registrar) Wm. Wallace Williams, M.D.

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 7, 1947, at 11 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Rev death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bacterial endocarditis
Empyema, left chest.

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 1/17/47

42 14

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47526

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G47526

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: Bon Secours Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 Emerald Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs. Helen Blanche Kohler

3 (b) If veteran, name war

3 (c) Social Security Account No. ✓

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife: Wilmer B. Kohler
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Jan 28, 1907

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 39 | 11 | 15 | hr. min. |

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Louis Herman
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Clara M. Wise
15. Birthplace: Baltimore

16 (a) Informant: Mrs. Herman
(b) Address: 2803 Emerald Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 16. 1937 (month) (day) (year)
(c) Cemetery or crematory: Parkewood
Location: Baltimore

18 (a) Funeral director: Rita Wudefeld
(b) Address: 2026 E. Biddle St.

19 (a) JAN 15 1937 (Date rec'd by registrar) [illegible]

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13 1937, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9 1937 to Jan 13 1937, and that I last saw h[illegible] alive on Jan 13 1937.

| Immediate cause of death | Duration |
|---|---|
| Ruptured left cardiac ventricle | |
| Due to Rheumatic heart - | |
| Due to decompensation | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: William F. Barr M. D.
Address: Bon Secours Hosp Date signed 1/14/37

VS 150

414 X

G17527.

CWK-107359

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937 ✓

Registered No. G17527

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
56- 1- 21-
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 627 S. Luzerne Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Carrie Haas

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21-1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 1 | 21 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Haas
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Julia Quigley
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 1/15/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Heights
Location Herman + Hill Rd.

18 (a) Funeral director Lilly + Zollenberg
(b) Address 403 S. Broadway

19 (a) JAN 15 1947 (b)
(Date received by registrar)

Huntington Williams, Registrar

V S 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 12 1947, at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 6 1947, to Jan. 12 1947, and that I last saw h. alive on Jan. 12 1947.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Hypertension & Uremia | |
| Due to | |
| Other Conditions Uremia | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert R. Fowler M. D.
Address Balto. City Hosp. Date signed 1-12-47

443 X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47528

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

Registered No. G47528

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 935 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Samuel D. Scarff

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Ossie Scarff

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 3 6 | 30 29 | hr. min. |

9. Birthplace Maryland (Upper Crossroads Harford Co.
(Town, county, and state)

10. Usual Occupation Filling Station Owner

11. Industry or business

FATHER
12. Name Charles T. Scarff
13. Birthplace Harford Co. Maryland

MOTHER
14. Maiden Name Martha Hitchcock
15. Birthplace Harford Co. Maryland

16 (a) Informant Wife
(b) Address 935 N. Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/47 (month) (day) (year)
(c) Cemetery or crematory Jerusalem Christian
Location Harford Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JAN 15 1947 (Date received by registrar) (Signature of registrar)

VS 151

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 1-14- 1947, at 10 A.M.

**21.** I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

**IMMEDIATE CAUSE OF DEATH** Cerebral Hemorrhage (intraventricular) Spontaneous

Due to

Other Conditions Bronchopneumonia.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Maldeis M.D.
Medical Examiner.
Date signed 1-14-47

331 X

G47529

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G47529 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1845 Kavanaugh St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1845 Kavanaugh St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** George Reynolds

3 (b) If veteran, name war

3 (c) Social Security Account No. 577-16-1219

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | C | married |

6 (b) Name of husband or wife Louise A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 5 | 1 | hr. min. |

9. Birthplace Raleigh, N. C.
(town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Louise A. Reynolds
(b) Address 1845 Kavanaugh St.

17 (a) Burial (b) Date thereof Jan. 15, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Geo. H. Holland
(b) Address 1631 Druid Hill Ave.
(c) Date received by registrar JAN 15 1947 Washington Williams M.D. Registrar

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/11/47 19 , at 12 N M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John J. Davis M.D.
Medical Examiner.
Date signed 1/12/47

42010

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47530 BC# G67176 EDeR ✓ BALTIMORE CITY HEALTH DEPARTMENT Registered No. G47530

# CERTIFICATE OF DEATH 1579

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Mercy Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 da.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3825 Belair Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Louis Matthew Eder

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age 1/6/47 years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1947

8. AGE: Years | Months | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Eder
13. Birthplace Baltimore

MOTHER 14. Maiden Name Anna Hirschowitz
15. Birthplace Baltimore

16 (a) Informant Hospital Record
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof Jan 15 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo D. Cook
(b) Address 1201-03 Patterson Park Ave

19 (a) JAN 15 1947 (b) Huntington-Williams M.P.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-14- 1947, at 6 30 pm M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h/ alive on 1-14- 1947

Immediate cause of death: respiratory failure — Duration: 9-days
Due to: congenital esophageal atresia
Due to: post-op. gastrostomy
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation 1-8-47
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James J. Garlach M. D.
Address Mercy Hosp. Date signed 1-14-47

VS 150

7552 X

G47534 Birth Certificate G-67736

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

159

G47531 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address Fayette, Calhoun St

(c) Hospital or institution Franklin Square Hospital

(d) Length of stay in hospital or inst (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2222 W. Saratoga St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

**3 (a) FULL NAME** Baby Boy Lyons.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14 - 1947

8. AGE: Years | Months | Days | If less than one day 1½ hr. — min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Charles C. Lyons

13. Birthplace Va

14. Maiden Name Ruth U. Pigott

15. Birthplace Checotah Okla

16 (a) Informant Irene M. Lyons

(b) Address 2222 W. Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 15-47 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location

18 (a) Funeral director Pratt & B. M. Walter

(b) Address Pratt & Pulaski Sts Huntington Williams, Mgr

19 (a) Date received (month) (day) (year) Registrar

JAN 15 1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 14 1949 at 3 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw him alive on Jan 14 1949.

Immediate cause of death Prematurity

Due to 3 2 weeks

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Walter Lasagna M. D.

Address 1429 W. Fayette St Date signed

776

Dr. Edw. Muller
2 West Road Street

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G47532

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2905 North Charles St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2905 North Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Josephine A. Bowersox

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widowed |

6 (b) Name of husband or wife William A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 4 | 24 | hr. 18 min. 84 |

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs Gerald Bowersox
(b) Address 2101 Dobler Avenue

17 (a) Burial (b) Date thereof 1/16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

JAN 15 1947
(Date rec'd by Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13th, 1947 at 1005 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1947 to Jan 13 1947 and that I last saw h[illegible] alive on Jan 13 1947

Immediate cause of death: Coronary Thrombosis — Duration 4 hr
Due to: Hypertensive Cardio-vascular Disease — 10 yrs
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Edwin Muller M. D.
Address 2 W Read St Date signed Jan 14 1947

VS 150

420.1 X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. James Kavanaugh
~~642503~~ Elderry St.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

97

Registered No. 642533

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1702 East 25th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 East 25th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Catherine Haver

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 7 | 5 | hr. min. |

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Michael Haver
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann Waters
15. Birthplace Ireland

16 (a) Informant Miss Mary Minton
(b) Address 1702 East 25th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

JAN 15 1947 (Date rec'd by Registrar)

(b) Huntington Williams M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 14 1947, at 2.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945, to 1-14 1947, and that I last saw her alive on 1-14 1947

| Immediate cause of death | Duration |
|---|---|
| ARTERIOSCLEROSIS | 10 yrs |
| Due to | |
| Due to | |
| Other Conditions HYPERTENSION. | 3 yrs |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry J. Kavanagh MD
Address 3728 Keswick Date signed 1-17-47 M. D.

450 X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47534

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

166

Registered No. G47534

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3203 Westfield Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Frederick Rahl Unger

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Edna Mae

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14 - 1908

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 38 | 4 | 30 29 | hr. min. |

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Police Officer

11. Industry or business

FATHER
12. Name Ferdinand J. Unger
13. Birthplace md

MOTHER
14. Maiden Name Georgia C. Hyatt
15. Birthplace Del.

16 (a) Informant Mrs. Edna M. Unger
(b) Address 3203 Westfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-16-47 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore Md.

18 (a) Funeral director Leonard J. Kuck
(b) Address 5305 Harford Rd

19 (a) JAN 15 1947 (Date rec'd by registrar) (b) Certified by Wm. Williams, M.D.

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 13, 1947, at 5-55 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gunshot of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/13/47 at 3 10 A. M.
(b) Where did injury occur? Preston & Bravard Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury Firearms

23. Signature Howard J. Williams M.D. Medical Examiner.
Date signed 1/13/47

E 951 M85X

G47535 Benson
1 W. Overlea Ave.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G47535

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4309 Berger Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4309 Berger Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Frances C. Holljes

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widowed |

6 (b) Name of husband or wife John L. Holljes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 2 | 23 | hr. min. |

9. Birthplace Beltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John Kran
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Ehring
15. Birthplace Germany

16 (a) Informant Mrs. Harry E. Goertz
(b) Address 315 Gittings Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/16/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) Date received by [illegible] 1947 (b) [illegible] Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 12, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9 1947 to Jan 12 1947 and that I last saw h.. alive on Jan 11 1947

Immediate cause of death — Duration
Coronary Disease — 3 yrs
Due to
Due to Coronary Thrombosis — 3 days
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Edgar W Benson M.D.
Address 1 W. Overlea Date signed 1/13/47

VS 150

420.1

G47536

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

G47536 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4214 Seidel Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Eleanor Kendall

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | W |

6 (b) Name of husband or wife Charles O.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | - | 20 | hr. min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. John Temple
(b) Address 4214 Seidel Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-47 (month) (day) (year)
(c) Cemetery or crematory Lakewood
Location Baltimore

18 (a) Funeral director L. J. Leyh
(b) Address 5305 Harford Rd.

19 (a) JAN 15 1947 (Signature of Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14 1947, at 3:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2 1947, to 1/14 1947, and that I last saw h alive on Jan 13 1947.

Immediate cause of death: Coronary Occlusion
Myocardial Infarction
and Embolic Phenomena

| Duration |
|---|
| |
| |
| |
| |
| |
| |
| |
| |

Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leon Rosenbaum Jr. M. D.
Address Sinai Hosp. Balt. Date signed 1/17/47

VS 150

4/2011

X

G47537

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G47537

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2712 Woodsdale Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Margaret B. Jenkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | married |

6 (b) Name of husband or wife Wesley S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 23-1902

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 47 | 0 | 22 | hr. min. |

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name James M. Erdman
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Jane Carlos
15. Birthplace Md.

16 (a) Informant Mr. Wesley S. Jenkins
(b) Address 2712 Woodsdale Ave

17 (a) Burial (b) Date thereof 1-17-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Kuck
(b) Address 5305 Harford Road

19 (a) JAN 15 1947 Washington Millspaugh, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-14-47 19 , at 10.4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11 1947 to 1-14 1947 and that I last saw her alive on 1-14- 1947

| Immediate cause of death | Duration |
|---|---|
| Coronary Occlusion | |
| Due to Bronchial Pneumonia | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard H. Young M. D.
Address St. Joseph's Hosp. Date signed 1/14/47

VS 150

4201 X

G47538 J. Alessi

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

93 ✓

Registered No. G47538

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 6304 Birchwood Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6304 Birchwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Elizabeth Louise Laucht

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widowed |

6 (b) Name of husband or wife Henry Laucht
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 5 | 5 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Henry Rothauge
13. Birthplace Germany

MOTHER
14. Maiden Name Louise ?
15. Birthplace Germany

16 (a) Informant Mr. Henry Laucht
(b) Address 6304 Birchwood Avenue

17 (a) Burial (b) Date thereof 1/17/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 JAN 15 1947 [illegible] Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 14th, 1947, at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/25 1940 to 1/14 1947
and that I last saw h. alive on 1/14 1947

Immediate cause of death Coronary Thrombosis
Arteriosclerotic cardiovascular
Due to disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation

of autopsy

| Duration |
|---|
| 1 day |
| 3 mos. |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 6217 Harford Rd Date signed 1/17/47

VS 130

420.1

X

G4753924

BALTIMORE CITY HEALTH DEPARTMENT X V

# CERTIFICATE OF DEATH 46B

Registered No. G47539

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Cecil
(c) City or town Cecilton
(If outside city or town limits, write RURAL and give town)
(d) Street No. –
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Jeter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Beasie Jeter

6 (c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.) 12-22-1889

8. AGE: Years 66 | Months 0 – | Days 22 | If less than one day: hr. min.

9. Birthplace Virginia (town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name James Jeter
13. Birthplace Virginia

MOTHER
14. Maiden Name Lucy McHorney
15. Birthplace Virginia

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 15, 1947 (month) (day) (year)
(c) Cemetery or crematory Family lot
Location Cecilton, Md

18 (a) Funeral director Chas. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) JAN 15 1947 (Signature of Registrar) Washington Williams M.D. Registrar

## MEDICAL CERTIFICATION

P

20. DATE OF DEATH 1-13-1947 at 6.23 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1947 to Jan 13 1947 and that I last saw him alive on Jan 13 1947

Immediate cause of death: Peritonitis, acute fibrinous, & generalized | Duration: < 7 days

Due to: Perforation of esophago-jejunostomy

Due to: Total gastrectomy, partial transverse colectomy; cholecystectomy

Other Conditions: for Carcinoma of Stomach | 6 mos.?
(Include pregnancy within 3 months of death)

Date of operation 1-7-47

Major findings of operation: Carcinoma of stomach

of autopsy: Peritonitis, pericarditis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bruce J. Franz M. D.

Address The Johns Hopkins Hosp. Date signed 1-13-47

MARGIN RESERVED FOR ENDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47540

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47540 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1211 Light St
(c) Hospital or institution: So. Baltimore Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days) ? [redacted] 20yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1322 Granby Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles McKnight

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-16-0729

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | N | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2 1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 52 | 11 | 11 | hr. min. |

9. Birthplace So. Carolina (Town, county, and state)

10. Usual Occupation
11. Industry or business Porter

FATHER: 12. Name Unknown
13. Birthplace West Indies Island

MOTHER: 14. Maiden Name Priscilla
15. Birthplace West Indies Island

16 (a) Informant Maggie Taylor
(b) Address 1322 Granby Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 17-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Jno Brooks
(b) Address 1463 N. Carey St

JAN 15 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 13 1947 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-2 1947 to 1-13 1947 and that I last saw h/ alive on 1-13 1947

| Immediate cause of death | Duration |
|---|---|
| (a) Cerebral Hemorrhage | |
| Due to (b) Hypertension | |
| Due to (c) | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rocco S. Laganito M. D.
Address So. Balto. Gen Hosp Date signed 1/14/47

VS 150

32 1 X

G17541

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G47541 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 788 W. Franklin
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Johnson

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7/4/1884
8. AGE: Years 62 | Months 6 | Days 7 | If less than one day hr. min.
9. Birthplace Baltimore, Maryland (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Carrie Johnson (D)
(b) Address 788 W. Franklin St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/47 (month) (day) (year)
(c) Cemetery or crematory Arlington Mem'l Pk
Location Balto. County, Md.
18 (a) Funeral director Chas. H. Hooper
(b) Address 510-12 N. Carrollton Ave.
19 (a) JAN 15 1947 (Date rec'd by registrar) (b) Carrington Williams M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 12 1947, at 1 30 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 12-18 1946 to 1-12 1947, and that I last saw him alive on 1-11-1947.

| | Duration |
|---|---|
| Immediate cause of death: Congestive Heart Failure. | |
| Due to: Arteriosclerotic Heart Disease. | |
| Due to: Hypertension | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address Date signed

G17542

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1/13

Registered No. G17542

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 324 N. Gilmore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 324 N. Gilmore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Joseph Donald Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Col. | Married |

6 (b) Name of husband or wife Sadie Brooks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1922

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 24 | 6 | 27 | hr. min. |

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name Joseph L. Brooks
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Virgie Randall
15. Birthplace Balto. Md.

16 (a) Informant Virgie Brooks
(b) Address 324 N. Gilmore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 17, 1947 (month) (day) (year)
(c) Cemetery or crematory Asbury Evergreen Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 2229 N. Edmondale St.

JAN 15 1947 Date rec'd by registrar Katie R. Williams, M.D.

V S 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/14 19 47, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2 19 47 to 1/14 19 47, and that I last saw h alive on 1/13 19 47.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Tuberculosis | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 2176 [illegible] Date signed 1/14/47

002

X

G47543 BC# G48313

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 107

G47543 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Loudon + Greene
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mos

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 527 W. Biddle (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Sandra Duncan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Child.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29-46

8. AGE: Years | Months 7 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Tomy Lorenzo ?
13. Birthplace

MOTHER 14. Maiden Name Margrett Duncan
15. Birthplace Baltimore Md.

16 (a) Informant Margrett Duncan
(b) Address 527 W. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-18-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 218 Druid Hill Ave.

18 (c) Date received JAN 15 1947 (Registrar) Thos. Wayne Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/14/1947, at 3:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 13 1947 to Jan 14 1947, and that I last saw her alive on Jan 14 1947.

| | Duration |
|---|---|
| Immediate cause of death Respiratory Failure | 2 days |
| Due to Broncho-Pneumonia; Acidosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. R. Ball M. D.
Address University Hosp Date signed 1/15/47

491 Baltimore Md. X

Bird Funeral Chapel

G47544 J-67936

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

G47547 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cause and age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd.
(c) Hospital or institution: Union Memorial Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 11½ hrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MARYLAND County
(b) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3903 Greenmount Ave, City 18
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ANNETTE IRENE BARRY

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1 | 12 | 47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | 11½ hr. min. |

9. Birthplace BALTIMORE MARYLAND
(Town, county, and state)

10. Usual Occupation INFANT

11. Industry or business

**FATHER**
12. Name JOHN MARSHALL BARRY
13. Birthplace BALTIMORE, MD.

**MOTHER**
14. Maiden Name ANNETTE I. STOUT
15. Birthplace BALTIMORE, MD.

16 (a) Informant JOHN MARSHALL BARRY
(b) Address 3903 Greenmount, City 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/47 (month) (day) (year)

(c) Cemetery or crematory Greenmount
Location Object Greenmount

18 (a) Funeral director John J. McGee
(b) Address 3000 E. Baltimore St.

JAN 15 1947
(Date rec'd by registrar) (b) Registrar

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 14 JANUARY 1947; at 11:00 AM

**21.** I certify that death occurred on the date above stated; that I attended deceased from 13 JAN. 1947 to 14 JAN 1947 and that I last saw her alive on 14 JAN 1947.

| Immediate cause of death | Duration |
|---|---|
| Respiratory Failure | |
| Due to Prematurity | 11½ hrs. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operations:
of autopsy: NONE

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward D. Cooper M. D.
Address Union Memorial Hospital Date signed 14 Jan 1947

Huntington Williams M.D.

776 X

G47545 | BALTIMORE CITY HEALTH DEPARTMENT | G47545

# CERTIFICATE OF DEATH

/108

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 6716 Fait Ave
(c) Hospital or institution: 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6716 Fait Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

**3 (a) FULL NAME** FELIX ZEZULINSKI ✓

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Widowed |

6 (b) Name of husband or wife Ida Skibinski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 11 | 6 | hr. min. |

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Vincent Powell
(b) Address 6716 Fait, Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 16 47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Rd.

18 (a) Funeral director Lilly & Zyla Inc.
(b) Address 403 S. Wolfe, St. Balto.

19 (a) JAN 15 1947 (b) (Date rec'd by registrar) Registrar

Clayton Williams, M.D.

VS 180

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/12 1947, at 10:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1947 to Jan 12 1947 and that I last saw ~~him~~ her alive on Jan 11 1947

Immediate cause of death (Coma) Apoplexy

| Duration |
|---|
| 6 Dy |

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clayton F. Williams M.D.
Address 1016 S. East Ave Date signed 1/15/47

490 X

G47546

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 5118

Registered No. G47546

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3317 W. Garrison Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3317 W. Garrison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ABRAHAM ROTTMAN

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M. | W | M |

6 (b) Name of husband or wife DORA
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | | | hr. min. |

9. Birthplace POLAND (Town, county, and state)
10. Usual Occupation TAILOR
11. Industry or business

FATHER
12. Name JACK
13. Birthplace POLAND

MOTHER
14. Maiden Name SARAH
15. Birthplace POLAND

16 (a) Informant WIFE
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-15-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phil Rd + Hamilton Ave

18 (a) Funeral director Jack Levin Inc.
(b) Address 1429 E. Balto St

19 (a) Date received by Registrar JAN 15 1947 (b) Registrar Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-15-47 19 40, at 12 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10 19 46 to 1-13 19 47.
and that I last saw him alive on 1-13 19 47.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of pelvic bone | |
| Due to Carcinoma of prostate | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 733 Forsyth St Date signed 1/15/47

185 X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47547

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 170c

G47547 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 229 S. Grams Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mathew Mandrow (Mandravickas)

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | white | Widowed |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not know

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| about 55 | | | hr. min. |

9. Birthplace Lithuanian (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name ? Mandravickas
13. Birthplace Lithuanian

MOTHER
14. Maiden Name Not know
15. Birthplace Lithuanian

16 (a) Informant Mrs. J. Benik
(b) Address White Marsh, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-16-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Road

18 (a) Funeral director John A. Krebs Jr.
(b) Address 423 S. Paca St

JAN 15 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 12, 1947 at 3 40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Broken neck, Fractured skull, Fractured pelvis

Due to

Other Conditions Multiple bruises

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: Balto, Md.,
(a) Date of injury 1/12/47 at 2:50 A. M.
(b) Where did injury occur? Route #40, 250' east of Route #700
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
Means of injury Pedestrian struck by auto

23. Signature Howard J. Mullens M.D.
Medical Examiner.
Date signed January 13, 1947

H804 X

G47548 BCH F78046

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G47548

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2521 James St Morrell Park
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Doris Ann Ritmiller

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20 1943

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 3 | 6 | 25 | 24 hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name G. Raymond Ritmiller
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elise G. Maser
15. Birthplace Baltimore, Md.

16 (a) Informant G. Raymond Ritmiller
(b) Address 2521 James St. Morrell Park

17 (a) Burial (b) Date thereof 1-17-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) (Date received by registrar) JAN 15 1947 Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-14 1947; at 8:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3 1947, to 1-14 1947, and that I last saw h[illegible] alive on 1-14 1947.

Immediate cause of death Respiratory failure — Duration
due to Terminal pulmonary edema
due to Acute Typhoid bacteremia
due to Lobar pneumonia
Other Conditions 1

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. B. Harley M. D.
Address Univ. Hosp. Date signed 1-19-47

X

G47549

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47549 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 213 E. 25th St.
(c) Hospital or institution: 12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 86 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 213 E. 25th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William G. Stewart

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife Almedia Stewart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11-1860

8. AGE: Years: 86 | Months: 11 | Days: 3 | If less than one day: hr. min.

9. Birthplace Baltimore - Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Ca. B. R.

FATHER 12. Name Walter Stewart

13. Birthplace Scotland

MOTHER 14. Maiden Name Margaret Stewart

15. Birthplace Baltimore - Md

16 (a) Informant Eliza Stewart

(b) Address 213 E. 25th ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan-16-1947 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park

Location Baltimore - Md

18 (a) Funeral director Durward L. Covington

(b) Address 21 W. 25th ST

19 (Signature) Huntington Williams, M.D.
Registrar

JAN 15 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14 1947, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1946, to Jan. 14 1947, and that I last saw him alive on Jan. 14 1947.

| | Duration |
|---|---|
| Immediate cause of death Chronic Myocarditis | 3 years |
| Due to General Arteriosclerosis | 3 years |
| Due to | |
| Other Conditions Pulmonary Edema | 6 hrs. |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry O'Reilly M. D.

Address 2504 St Paul St. Date signed 1/15/47

VS 8

422.1 X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47550

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

Registered No. G47550

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 104 E. 25th St.
(c) Hospital or institution: none 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 E. 25th St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Adella Deale Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Albert Robert Hall, Sr.

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) June 24, 1887

8. AGE: Years 59 | Months 6 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name John S. Deale
13. Birthplace Manchester, Md.

MOTHER
14. Maiden Name Annie M. Vail
15. Birthplace Baltimore, Md.

16 (a) Informant Albert R. Hall, Sr.
(b) Address 104 E. 25th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/16/47 (month) (day) (year)

(c) Cemetery Lorraine
Location Windsor Mill Rd. Woodlawn, Md.

18 (a) Funeral director John D. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) JAN 15 1947 Registrar

VS 151

JAN 1: 47

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/14/47 19 at 4:30p M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Peters M.D.
Medical Examiner.
Date signed 1/15/47

4201 X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47551

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G47551

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1609 E 25th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 E 25th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles C Coulter

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | |

6 (b) Name of husband or wife Carrie J Coulter
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Oct 9 1869

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 3 | 4 | hr. min. |

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Andrew Coulter
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Sarah McDonald
15. Birthplace Baltimore Md

16 (a) Informant Mrs Carrie Coulter
(b) Address 1609 E 25th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 16-47 (month) (day), (year)
(c) Cemetery or crematory Greenmount
Location Lot

18 (a) Funeral director Charles P Powell
(b) Address 2427 Edmondson Ave

19 (a) JAN 15 1947 Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1947, at 1050 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/15 1946, to 1/13 1947, and that I last saw him alive on 1/13 1947.

| Immediate cause of death | Duration |
|---|---|
| Acute Coronary infarction | |
| Due to Ch General arteriosclerosis; | |
| Due to Ch Myocarditis. | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature A. H. Hornstein M. D.
Address 733 Asquith St Date signed 1/14/47

42611 X

G47552 G47552A

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46B

Registered No. G47552 D47552

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 916 N. Arlington ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 916 N. Arlington ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Emma Granderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16 75

8. AGE: Years 71 | Months 9 | Days 26 | If less than one day: hr. min.

9. Birthplace Lancaster, Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Thomas Granderson
13. Birthplace Va

MOTHER 14. Maiden Name Hewetta
15. Birthplace Va

16 (a) Informant Florence Smith
(b) Address 916 N. Arlington ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/47 (month) (day) (year)
(c) Cemetery or crematory Arlington Mem. Pk.
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brentley ave

JAN 15 1947 (Date received by registrar) (b) Burlington Williams, M.D. (Signature of registrar)

VS 150

**MEDICAL CERTIFICATION**

1/11/47 945 Pm

**20. DATE OF DEATH** 1/11/47 19 945 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/21/46 to 1/11/47, and that I last saw h alive on 1/10/47 19

Immediate cause of death: Gangrene Stomach — Duration: Years

Due to: Edema — Duration: Months

Due to: — Duration: Days

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alice Ellis M. D.
Address 916 N. Arlington ave Date signed 1/15/47

151 X

G47553

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G47553

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 535 Preestman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 535 Preestman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Tecumseh Abayenie Woodland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife Alice A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29 1897

8. AGE: Years 49 | Months 5 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Thomas Woodland
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sarah Brooms
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Edith Marshall
(b) Address 595 Preestman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 16, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lucy A. Holland
(b) Address 691 Druid Hill Ave

JAN 15 1947 (Date rec'd by Registrar) (b) Huntingtor Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 1947, at 1.10 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 11 1947 to Jan 13 1947. and that I last saw h — alive on Jan 13 1947.

Immediate cause of death Coronary Thrombosis — Duration 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Norman Higgins M. D.

Address 2243 Madison Ave Date signed 1/14/47

420.1 X

G47554 Birth Certificate Y-67 D48

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 159

Registered No. G47554

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Broadway & Hairmount
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hr 37 min.
(e) Length of stay in Baltimore (yrs., mos., or days) Same

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 826 Braeside Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Germon

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-12-47

8. AGE: Years | Months | Days | If less than one day: 10 hr. 37 min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business —

FATHER
12. Name Sheldon German
13. Birthplace Maryland

MOTHER
14. Maiden Name Evelyn Butler
15. Birthplace Maryland

16 (a) Informant Mrs Sheldon German
(b) Address 826 Braeside Road, Balt.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Loca Johns Hopkins Medical School JAN 14 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 15 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 130

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-13 1947, at 12:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-12 1947 to 1-13 1947, and that I last saw him alive on 1-13 1947.

Immediate cause of death Prematurity — Duration —

Due to Premature separation of low implanted placenta — 36 hrs

Due to — —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wayne N. Jacobus, M.D.
M. D.
Address Church Home & Hosp. Date signed Jan 15/47

774 X

G47555

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G47555
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1021 Capiston street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 Capiston St.
(If rural give location)
(e) Citizen of foreign country? Capiston St (Yes or No)
If yes, name country

**3 (a) FULL NAME** JOSEPH D. GALINAC

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife Catherine T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1913

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 33 | 1 | 13 | hr. min. |

9. Birthplace Vanderbilt, Penna.
(Town, county, and state)
10. Usual Occupation Store Room Clerk
11. Industry or business Davidson Chemical Co.

FATHER
12. Name Joseph G. Galinac
13. Birthplace Unknown

MOTHER
14. Maiden Name Barbara Doljac
15. Birthplace Unknown

16 (a) Informant Catherine T. Galinac
(b) Address 1021 Capston Court

17 (a) Removal (b) Date thereof JAN 16 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Uniontown, Penna.

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 217 St. Paul Street

JAN 15 1947

19 (a) [illegible] Registrar
(Date rec'd by registrar)

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15, 1947, at 6.30 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 1-15-47

420.1

G47556 BALTIMORE CITY HEALTH DEPARTMENT X G47556
Registered No.

# CERTIFICATE OF DEATH 1937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. This correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1301 Park
(c) Hospital or institution: Miss Smith's Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mo-8 ds.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Mo-8 da.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State N. Y. (b) County N. Y. City.
(c) City or town New York City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 130-E-63rd Street.
(If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country

**3 (a) FULL NAME** Margaret Anne Stewart Cooper

3 (b) If veteran, name war: no
(c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife: Julian J. Cooper
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July-20-1870

8. AGE: Years 76 | Months 5 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation none
11. Industry or business none

FATHER
12. Name John D. Stewart
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Mary E. Griffith
15. Birthplace Balto. Md.

16 (a) Informant Miss Mildred Cassidy (niece)
(b) Address Severn Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 16-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Stewart Mann Company
(b) Address 108 W North Ave.

19 (a) ... (Date rec'd by registrar) (b) ... Williams, M... trar

JAN 15 1947

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Jan 14 1947, at 6 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1946 to Jan 14 1947 and that I last saw him alive on Jan 14 1947.

Immediate cause of death: Hypocenditis Arteio-Sclerosis — Duration: Finished

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Cassidy
Address 1403 Park Ave Date signed 1/15/47 (M. D.)

4221 X

G47557 BALTIMORE CITY HEALTH DEPARTMENT X G47557
CERTIFICATE OF DEATH 55a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½ mos
(e) Length of stay in Baltimore (yrs., mos., or days) 3½ mos

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Anne Arundel
(c) City or town Lakeville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ramona Zang ZANG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/25/31

8. AGE: Years 15 | Months 11 | Days 20 21 | If less than one day ____ hr. ____ min.

9. Birthplace Annapolis Md.
(Town, county, and state)

10. Usual Occupation school girl

11. Industry or business

FATHER
12. Name Arthur Vernon Zang
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Pearl Norwood
15. Birthplace East Bott Md.

16 (a) Informant Arthur V. Zang
(b) Address West River A.A. Co. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/47 (month) (day) (year)
(c) Cemetery or crematory West River
Location A.A. Co. Md.

18 (a) Funeral director Miller Funeral
(b) Address 1003 N. Eutaw Street

19 (a) (Signature by registrar) (b) Registrar

JAN 1 6 1947

Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 15 1947, at 1:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1946 to Jan 15 1947 and that I last saw ____ alive on Jan 15 1947.

Immediate cause of death Cardiovascular collapse — Duration

Due to Malignancy of the abdominal cavity- origin ? type to await

Due to frozen section

Other Conditions Obstruction jaundice

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Malignancy, site & type to follow

over

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. E. Stallenberg Jr. M. D.
Address University Hospital Date signed 1-17-47

G47558 NORTHAM

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G47558 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 704 Wyndhurst Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 d
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 704 Wyndhurst Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth M Northam

3 (b) If veteran, name war — 3 (c) Social Security Account No. none

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife George R Northam
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 14. 1861

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 85 | 3 | 1 | hr. min. |

9. Birthplace Virginia (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank W Mullin
13. Birthplace New York

MOTHER
14. Maiden Name Mary J Meskell
15. Birthplace Ohio

16 (a) Informant Mrs Lathon M Dobson
(b) Address 704 Wyndhurst Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/47 (month) (day) (year)
(c) Cemetery or crematory Jerusalem Cemetery
Location Emmorton Md

18 (a) Funeral director Fulton & Son
(b) Address 2174 Eastern Ave

JAN 16 1947 (Date received by Registrar) [illegible] Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 15 1947, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1946 to 15 Jan 1947, and that I last saw her alive on 1st Jan 1947

Immediate cause of death: Bronchopneumonia — Duration 5 days
Due to: Myocarditis — 15 yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: None
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Howard Harper M.D.
Address 35 E Ellerslie Date signed 16 Jan 47

VS 150

422.2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G17559

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1946

Registered No. G17559

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 1/1/47 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 909 N. Bradford St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Bessie Marie Kliment

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or ~~wife~~: Emanuel Kliment

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 11, 1896

8. AGE: Years 50 | Months 11 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace: Czechoslovakia
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Frank Pronek
13. Birthplace: Czechoslovakia

MOTHER
14. Maiden Name: Anna Safderova
15. Birthplace: Czechoslovakia

16 (a) Informant: Mr. Emanuel Kliment
(b) Address: 909 N. Bradford St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/16/1946 (month) (day) (year)
(c) Cemetery or crematory: Oak Hill
Location: Horner's Lane, Baltimore, Md.

18 (a) Funeral director: Charles E. Schimunek
(b) Address: 2601-03 E. Madison Street

19 (a) JAN 16 1946 Registrar (b) Registered

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/13 1947, at 11:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Asphyxiation under anaesthesia

Due to: Aspiration of blood in trachea.

Other Conditions: Chronic Tonsillitis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 20/1
(a) Date of injury 1/13/47 at about 10:45 A.M.
(b) Where did injury occur? Bon Secours Hospital
(c) Did injury occur at home, on farm, industrial place, in public place? Hospital While at work? No
(d) Means of injury Aspiration of blood

23. Signature: F. J. Sulecinski M.D.
Medical Examiner.
Date signed 1/13/47

VS 191

510.1 X

G47560 Gilliam

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G47560

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 617 Gilbert St.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 617 Gilbert St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Cosby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Lillian Cosby

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/4/1899

8. AGE: Years 47 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace Louisville Kentucky (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

MOTHER / FATHER

12. Name Unknown

13. Birthplace

14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Lillian Cosby

(b) Address 617 Gilbert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/16/47 (month) (day), (year)

(c) Cemetery or crematory Baltimore National

Location Gloyd Wilson

18 (a) Funeral director 1000 Edmondson Ave

(b) Address

19 Date received JAN 16 1947 (b) by [illegible] Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13 1947; at 5a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1947 to Jan 13 1947 and that I last saw him alive on Jan 11 1947

Immediate cause of death Coronary Thrombosis — Duration

Due to Coronary Heart Disease. — 1 yr.

Due to

Other Conditions Hypertension.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jas. A. Julian Jr.

Address 516 Eutaw St. Date signed 1/16/47

420.1 X

G47561

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 107

Registered No. G47561

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1306 Stricker St.
(c) Hospital or institution: 15-
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 Stricker St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Coates

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Unknown

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) ?-?-1881

8. AGE: Years: 66 | Months: 65 | Days: | If less than one day: hr. min.

9. Birthplace Calvert Co. Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER — 12. Name Major Parran

13. Birthplace Calvert Co Md

MOTHER — 14. Maiden Name Lucretia Galloway

15. Birthplace Calvert Co. Md

16 (a) Informant Mrs Mary F. Myers

(b) Address 1306 W Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-18-47 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director George G. Nelson

(b) Address 1303 Pennsylvania Ave

19 (a) [illegible] (b) [illegible] Williamsport Md

JAN 20 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-15- 1947, at 130 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-13- 1946, to 1-15- 1947 and that I last saw h[illegible] alive on 1-14- 1947

Immediate cause of death: Bronchopneumonia — Duration: 5 Days

Due to:

Due to: Bronchitis — Duration: unknown

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank J. A. Saunders M. D.

Address 1029 N. Stricker Date signed 1-15-47

VS 150

X

G47562

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 52 B

Registered No. G47562

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4212 Parkmont Ave.
(c) Hospital or institution: Parkmont Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 320 E. 20th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** RICHARD J. WINDER

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widower |

6 (b) Name of husband or wife Lucy Crofton Winder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1858

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 88 | 11 | 29 | hr. min. |

9. Birthplace Matthews Co., Va. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Winder
13. Birthplace Matthews Co., Va.

MOTHER
14. Maiden Name Susan James
15. Birthplace Matthews Co., Va.

16 (a) Informant Mr. Samuel Styers
(b) Address 3220 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JAN 16 1947 (b) Hampton Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 15, 1947 at 1:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Jan 15 1947
and that I last saw him alive on Jan 15 1947
Immediate cause of death Coronary Thrombosis Duration
Due to Metastasis to Lungs.
Due to
Other Conditions: Arteriosclerotic Cardio-Vascular Disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. J. Stevens M.D.
Address 3400 Eastern Ave. Date signed 1/16/47

VS 150

X

G47563

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

G47563
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 407 Lorraine Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 3
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 407 Lorraine Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: IDA J. HAYMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Millard J. Hayman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1860

8. AGE: Years 86 | Months 11 | Days 20 21 | If less than one day hr. min.

9. Birthplace Somerset Co., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Daniel J. Crockett
13. Birthplace Somerset Co., Md.

MOTHER
14. Maiden Name Sarah Fitzgerald
15. Birthplace Md.

16 (a) Informant Mrs. Bernice H. Morgan
(b) Address 407 Lorraine Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/47 (month) (day) (year)
(c) Cemetery or crematory Methodist Cemetery
Location Pocomoke City, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 JAN 16 1947 (Date rec'd by Reg.) (b) [illegible] Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14, 1947 at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15th. 1946 to Jan. 14th 1947; and that I last saw her alive on Jan. 6th. 1947.

| | Duration |
|---|---|
| Immediate cause of death: Uremia | few days |
| Due to: Chronic Interstitial Nephritis | unknown |
| Due to: | |
| Other Conditions: Secondary Anemia | unknown |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jos. W. Montgomery M.D.
Address 401 E. 25th. St. Date signed 1/15/47.

VS 150

G47564

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 97

G47564 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2422 Barclay St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Generoso Pavese

3 (b) If veteran, name war: Spanish American
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lucy Pavese
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-30-65

8. AGE: Years 81 | Months 11 | Days 16 | If less than one day: hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Engineering Instructor
11. Industry or business (Retired)

FATHER: 12. Name Rocco Pavese
13. Birthplace Italy

MOTHER: 14. Maiden Name Giuditta Nonis
15. Birthplace Italy

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JAN 16 1947 (Date rec'd by Registrar) (b) [illegible] M.D.

VS 130

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 15 1947 at 9 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1947 to Jan 15 1947 and that I last saw him alive on Jan 15 1947.

Immediate cause of death: Cardiac failure — Duration: * 2 wks
Due to: Arteriosclerosis
Due to:
Other Conditions: B.P.H.

(Include pregnancy within 3 months of death)
Date of operation: Not
Major findings of operation:
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [illegible] M. D.
Address Date signed

X

G47565

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 55E

Registered No. G47565

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1743 Orleans St
(c) Hospital or institution: D&A 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1743 Orleans St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** George Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | W |

6 (b) Name of husband or wife Lillie Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/29/1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 5 | 13 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Johnson
13. Birthplace Md

MOTHER
14. Maiden Name Mary ?
15. Birthplace Md

16 (a) Informant Irvin Johnson
(b) Address 1734 Orleans St

17 (a) Burial (b) Date thereof 1/15/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy A Wilson
(b) Address 1000 Brantly Rd

19 JAN 16 1947 Elroy A Wilson
(Date received by local registrar) (Signature of local registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/12 1947, at 10¼ M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Generalized Arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. D. Johnson M.D.
Medical Examiner.
Date signed 1/17/47

VS 151

G47566 BALTIMORE CITY HEALTH DEPARTMENT G47566

# CERTIFICATE OF DEATH 93c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1915 Guilford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-4
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 Guilford Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** John R. Carr

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| male | white | Divorced |

6 (b) Name of husband or wife Minnie Carr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 4 | 29 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business Taxi Cab.

FATHER
12. Name Rosby Carr
13. Birthplace England

MOTHER
14. Maiden Name Anna Carr
15. Birthplace

16 (a) Informant Mrs. Nylan Hunter
(b) Address 1915 Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 17, 1947 (month) (day) (year)
(c) Cemetery or crematory Mountain View Christian
Location Harford Co., Md.

18 (a) Funeral director H. K. McComas & Son
(b) Address Abingdon, Md.

19 (a) JAN 16 1947 (Date rec'd by registrar)

VS 3

**MEDICAL CERTIFICATION**

20. DATE OF DEATH JANUARY 14 1947, at 7.57 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/16 1940 to 1/14 1947 and that I last saw h/m alive on 1/14 1947.

Immediate cause of death RHEUMATIC CARDIO-VASCULAR DISEASE — Duration 6 yrs.
Due to & MYOCARDITIS.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard Klemm M. D.
Address 3803 Edmondson Ave Date signed 1/16/47

G47567 In Baltimore C.G. 72989

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

161a

Registered No. G47567

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 hrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3 Barrett Cove (If rural give location) Arbutus
(e) Citizen of foreign country? No. (Yes or No) 3-27
If yes, name country

3 (a) FULL NAME Baby J Margaret Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Negro. | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 16 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | 8 hr. min. |

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Pendleton Davis
13. Birthplace Bristol Va.

MOTHER
14. Maiden Name Margaret Williams
15. Birthplace Balto. Md.

16 (a) Informant Margaret Davis
(b) Address 3 Barrett Cove.

17 (a) Burial (b) Date thereof Jan 16 1947 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

JAN 16 1947 (b) Mrs Katie R. Williams, M.D.
(Filed) (Registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-12-1947 at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11-47 1947 to 1-12-1947, and that I last saw him alive on 1-12 1947.

| Immediate cause of death | Duration |
|---|---|
| Congenital Atelectasis | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M & K. Greeley
Address 756-Dolphin St. Date signed 1/14/47 (M. D.)

X

Birth Certificate G-68105

G47568

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47568

Registered No. 161c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3022 Windsor Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy Ruckle

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-14-47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 1 | hr. min. |

9. Birthplace md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Francis Ruckle

FATHER 13. Birthplace md.

MOTHER 14. Maiden Name Catherine Ahearn

MOTHER 15. Birthplace md

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/16/47 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director H. C. Wurmser & Sons

(b) Address 205 W. Calvert St.

JAN 16 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

C

20. DATE OF DEATH Jan. 14 1947 at 10.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14 1947 to Jan 14 1947 and that I last saw him alive on Jan 14 1947.

| Immediate cause of death | Duration |
|---|---|
| Erythroblastosis fetalis | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Russell Jordan M. D.

Address The Johns Hopkins Hospital Date signed 1-15-47

X

G47569

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G47569 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 63 Yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 752 Overbrook Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

**3 (a) FULL NAME** Lily M. Kesmodel

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | wh. | widowed |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | | 16 | hr. min. |

9. Birthplace Balto - Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John L. McCoy
13. Birthplace Balto

MOTHER
14. Maiden Name Lily Schoof
15. Birthplace Balto

16 (a) Informant Mary Frances Kuhfuss
(b) Address 752 Overbrook Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meads and Son
(b) Address 805 N. Calvert Street

19 (a) Date received by Registrar JAN 16 1947 (b) [illegible] Williams

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan - 14 - 1947, at 2.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan - 13 1947 to Jan - 14 1947, and that I last saw h.e alive on Jan 14 1947.

Immediate cause of death Acute Cardiac Failure — Duration

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address V.M.H. Date signed 1/17/47

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47570

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH / 937

Registered No. G47570

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2049 Panna. ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-3
(e) Length of stay in Baltimore (yrs., mos., or days) 65-yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2049 Panna. ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Celia Banks.

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860

8. AGE: Years 87 86 | Months | Days | If less than one day hr. min.

9. Birthplace Calvert Co., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Eli Rice
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Amelia Ray
15. Birthplace Calvert Co. Md.

16 (a) Informant Edna Wilson
(b) Address 2049 Panna. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof JAN 17 1947 (month) (day) (year)
(c) Cemetery or crematory St Peters Cemetery
Location W. Baltimore

18 (a) Funeral director W. Brooks
(b) Address 1463 N. Carey st

JAN 16 1947 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-13- 1947, at 8:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10, 1946 to Jan 13 1947. and that I last saw h alive on Jan 13 1947.

| Immediate cause of death | Duration |
|---|---|
| Hypertensive Heart | 6 Mos. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George C. Page M. D.
Address 1516 N. Mount St (17) Date signed 1-16-47

X

G47571

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH √309

Registered No. G47571

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 546 Dolphin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Samuel Heath

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-5397

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Black | Widowed |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-8-83

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 10 | 6 | hr. min. |

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER 12. Name Samuel Heath
13. Birthplace Va.

MOTHER 14. Maiden Name Ada Button
15. Birthplace Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Jan 17-46 (month) (day) (year)
(c) Cemetery or crematory Philadelphia
Location Penna.

18 (a) Funeral director Wm Crooks
(b) Address 1437 N. Carey St

19 (JAN 16 1947) (Date received by registrar) (Signature of Registrar) Geo. Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 14 1947 at 8 55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 16 1946 to Jan 14 1947 and that I last saw he was alive on Jan 14 1947

Immediate cause of death Cardiac failure — Duration

Due to Retained embalming fluid

Due to

Other Conditions Fatal syphilis
Emphysema - senile
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Retained embalming fluid

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund L Dyson

Address Johns Hopkins Hospital Date signed 1-17-47

VS 130

91a

G47572

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G47572 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address MONUMENT ST.
(c) Hospital or institution: SINAI HOSP. 7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County BALTO.
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2509 Mc ELDERRY
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** CHARLES N. MANLEY

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | MARRIED |

6 (b) Name of husband or wife [redacted] NANNIE D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-12-1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 8 | 3 | hr. min. |

9. Birthplace OCESOLA PA.
(Town, county, and state)
10. Usual Occupation GARAGE ATTENDANT
11. Industry or business

FATHER
12. Name MAHLIN V. MANLEY
13. Birthplace PA.

MOTHER
14. Maiden Name ? METZGER
15. Birthplace PA.

16 (a) Informant NANNIE MANLEY
(b) Address 2509 McELDERRY

17 (a) BURIAL (b) Date thereof 1-20-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE.

18 (a) Funeral director Lilly & Zieler Inc
(b) Address 1403 E. Wolfe St.

19 (a) 1/18/47 [illegible]
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH JAN 15 1947, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 19 47 to Jan 15 19 47, and that I last saw h Dead on arrival alive on Jan 15 19 47

Immediate cause of death Coronary Art Disease — Duration

Due to Pulm. Edema.

Due to Cardiac Failure

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leon Rountree Jr M. D.
Address Sinai Hosp., Balt. Md. Date signed Jan 15, 47

VS 150

For Wm. S. Haggerty, by Howard L. Mullins, M.D.

G47573

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 186a

G47573 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3019 St Paul st
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) (0)
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3019 St Paul st (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Hannah Thomas (HANNAH STUART SCOTT THOMAS)

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: J. B. Thomas (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26 1862

8. AGE: Years 84 | Months 3 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore Laurel Md (Town, county, and state)

10. Usual Occupation Home wife (Retired)

11. Industry or business

FATHER — 12. Name James Dealt
13. Birthplace England

MOTHER — 14. Maiden Name Arthur E Alice
15. Birthplace Great Britain and Ireland

16 (a) Informant Mrs H. M. Scott (Son)
(b) Address 2112 St Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 17 47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn

18 (d) Funeral director Stewart-Morris Company
(b) Address 108 W North Av

19 (a) Date received by registrar JAN 16 1947 (b) Registrar Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 15 1947 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1947 to Jan 15 1947, and that I last saw h alive on Jan 14 1947.

Immediate cause of death: Fractured Femur

Due to

Due to Fracture of Hip.

Other Conditions Age

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Fall in Home
(b) Date of occurrence Jan 3 at 2 P M
(c) Where did injury occur? At Home (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? At Home While at work? (Specify type of place)
(e) Means of injury Slipped in home (N.J.M.)

23. Signature John H Crans M. D.
Address 612 N Eutaw Pl Date signed

Howard J. Morris, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G47574

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47574 Registered No. 194a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address TRAYNOR AVE 27
(c) Hospital or institution: WEST BALTO. GENERAL HOSPT
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 YRS

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5104 SUNSET RD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** (SPIEGEL) FANNY SPIEGEL

3 (b) If veteran, name war

3 (c) Social Security Account No. -

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| FEMALE | WHITE | MARRIED |

6 (b) Name of husband or wife FRANK H

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | | | hr. min |

9. Birthplace RUSSIA
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

**FATHER**
12. Name LOUIS
13. Birthplace RUSSIA

**MOTHER**
14. Maiden Name BELNH
15. Birthplace RUSSIA

16 (a) Informant WM. SPIEGEL- SON
(b) Address 5104 SUNSET RD

17 (a) BURIAL (b) Date thereof 1-17-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ARLINGTON CEM.
Location ROGERS AVE

18 (a) Funeral director JACK LEWIS INC
(b) Address 2100 EUTAW PLACE

JAN 16 1947 (b) [illegible]
(Date rec'd) (Registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 15 1947, at 4 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from DEC 28 1946 to JAN 15 1947 and that I last saw her alive on JAN 15 1947.

Immediate cause of death MYOCARDIAL INFARCTION — Duration

Due to CORONARY OCCLUSION

Due to

Other Conditions PNEUMONIA RIGHT LOWER LUNG
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy MYOCARDIAL INFARCTION

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Rubenstein, M. D.
Address 3706 Rosedale Rd Date signed 1/16/47

X

G47575

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

G47575 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address MONUMENT ST
(c) Hospital or institution: SINAI HOSPT
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 D
(e) Length of stay in Baltimore (yrs., mos., or days) 70 YRS

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3525 DOLPHIN AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** DORA WEISMAN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| FEMALE | WHITE | MARRIED |

6 (b) Name of husband or wife ABRAHAM W. WEISMAN
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | | | hr. min. |

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name NOT KNOWN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace RUSSIA

16 (a) Informant HOSPT RECORDS
(b) Address

17 (a) BURIAL (b) Date thereof 1-17-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL
Location CERTON HILL RD

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

JAN 16 1947 (b) [illegible]
(Date received by registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-16-47 19 , at 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/30 1946 to 1/16 1947, and that I last saw h[illegible] alive on 1/15 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebro Hass. Accident | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stanley W Yoh M.D.
Address Sinai Hosp Date signed 1/16 47

G475576

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

Registered No. G475576

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 424 N. Exeter St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-

(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 424 N. Exeter St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

2

3 (a) **FULL NAME** Mary Frances ~~Hughes~~ Idagens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife James J. Idagens
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4th 1877

8. AGE: Years 69 70 | Months 8 | Days 9 | If less than one day hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name —
13. Birthplace Ireland

MOTHER
14. Maiden Name —
15. Birthplace Ireland

16 (a) Informant James Idagens
(b) Address 424 N Exeter St

17 (a) Burial (b) Date thereof Jan 17th 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edgewood Ave

18 (a) Funeral director Leo F. Leach
(b) Address 1701-03 N Patterson Park Ave

19 JAN 16 1947 (b) Twentieth Ward

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 13, 1947, at 6.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944, to Jan. 1947, and that I last saw h[illegible] alive on Jan 12 1947

| Immediate cause of death | Duration |
|---|---|
| Carcinomatosis | 3 mos |
| Due to Carcinoma of breast | 3 yrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Pekorny M.D.

Address 2260 E Madison St Date signed 1/15/47

VS 150

G17577

506526.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

Registered No. G17577

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Allegheny
(c) City or town Cumberland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 326 N. Centre St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Robert Thaler

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-14-35

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 11 | 4 | 1 | hr. min. |

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Lloyd Thaler

13. Birthplace md.

MOTHER 14. Maiden Name Frances Keller

15. Birthplace Germany

16 (a) Informant Friends.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Rosedale Gardens

Location Cumberland, Md

18 (a) Funeral director John O Mitchell & Sons

(b) Address 1760 Easton Place.

19 (a) JAN 16 1947 (b) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan - 15 1947 at 7.47 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec - 17 1946 to Jan - 17 1947, and that I last saw him alive on Jan - 17 1947

| Immediate cause of death | Duration |
|---|---|
| Congestive Heart Failure | 31 days |
| Due to Myocardial Infarctura | |
| Due to Coronary Thrombosis | |
| Other Conditions Extensive burns of legs and abdomen (Include pregnancy within 3 months of death) | |
| Date of operation | |
| Major findings of operation: | |
| of autopsy Myocardial Infarction | |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence April 1945 at — M
(c) Where did injury occur? 326 N. Centre St (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? no
(Specify type of place)
(e) Means of injury Unknown

23. Signature Albert J. Sheldon M.D.
Address Date signed 1/16/47

Howard J. Mengert, M.D.

G47578

BALTIMORE CITY HEALTH DEPARTMENT ✓ G47578 Registered No.

# CERTIFICATE OF DEATH 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1816 N. Bentalou st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 3

(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1816 N. Bentalou st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Fannie Snesil

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | white | Married |

6 (b) Name of husband or wife Benjamin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business House Wife

FATHER
12. Name Ralph Levine
13. Birthplace Russia

MOTHER
14. Maiden Name Brina Levine
15. Birthplace Russig

16 (a) Informant Benjamin Snesil
(b) Address 1816 N Bentalou st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 17, 1947 (Month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location 3600 E Balto St

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1124-26 W Mt Royal ave

19 (a) (Date received by Registrar) (b) Registrar

JAN 16 1947 Hampton Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/15/47 19 , at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1946 to 1/15 1947, and that I last saw her alive on 1/15 1947.

Immediate cause of death Cerebral Hemorrhage — Duration 6 weeks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benj. Samuelson M.D.
M. D.
Address 2128 W North Ave Date signed 1/15/47

G47579

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93c

G47579 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1930 Breitwent Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1930 Breitwent Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** Mr. George Howard Block

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| World War I | 216-03-4783 |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Myrtle Viola
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) June 4, 1896 ?

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 7 | 11 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Foreman - ~~Watchmaker~~
11. Industry or business Western Electric

FATHER
12. Name Frank Block
13. Birthplace Council Bluff Iowa

MOTHER
14. Maiden Name Bertha Rausch
15. Birthplace Chemnitz, Germany

16 (a) Informant Wife
(b) Address 1930 Breitwent Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/47 (month) (day) (year)
(c) Cemetery or crematory M. R. Of Lust
Location Frederick Rd.

18 (a) Funeral director Edward Fenhorn
(b) Address 2859 Wash. Blvd

19 (a) JAN 16 1947 (Date received by registrar) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 1947, at 10 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 7 1946, to Jan 14 1947, and that I last saw him alive on Jan. 14 1947.

| | Duration |
|---|---|
| Immediate cause of death Coronary Failure | |
| Due to Rheumatic Cardio-Vascular Disease | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Arthur Rossberg M. D.
Address 3411 Wash. Blvd. Date signed 1/15/47

VS 2

X

G47580

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 166

G47580 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 513 S. Ann Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Helen Terence Sykimicz

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-18-7615

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Witold (Walter) Sykimicz

6 (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) March 2, 1925

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 21 | 10 | 13 | ....hr. ....min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Frank Ference
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Barylewicz
15. Birthplace Poland

16 (a) Informant Stanley Ference
(b) Address 532 S. Ann St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 18 47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location German Hill Rd.

18 (a) Funeral director Mark E. Hopps Son
(b) Address 37 S. Ann St. Baltimore, Md.

19 (a) 1/16/47 (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 16 1947, at 3:45 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gunshot wound of the heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-15-47 at 3:30 P M.
(b) Where did injury occur? Ann St. & Eastern Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury firearms

23. Signature Howard J. Muellein M.D. Medical Examiner.
Date signed 1-16-47

VS 191

G17581

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G17581

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 21
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 64yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1229 Carroll St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Henry W Rang.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White. | married |

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age 79. years

7. Birth date of deceased (mo., day, yr.) 8-18-1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 4 | 28 | hr. min. |

9. Birthplace Germany. (Town, county, and state)

10. Usual Occupation Cabinet Maker

11. Industry or business

FATHER 12. Name ? ?

FATHER 13. Birthplace ?

MOTHER 14. Maiden Name ? ?

MOTHER 15. Birthplace ?

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/19/47 (month) (day) (year)

(c) Cemetery or crematory Western

Location Balto Md

18 (a) Funeral director Harry H Weltz

(b) Address 410 Edmondson Ave

19 (a) Jan 16 1947 (b) [illegible] Williams M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 16 1947, at 3. A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan - 16 1947 to Jan - 16 1947, and that I last saw him alive on Jan - 16 1947.

| Immediate cause of death | Duration |
|---|---|
| Shock | |
| Due to Coronary occlusion | |
| Due to Arteriosclerotic heart | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 1-16-47

G47582 BC# G67409 X ✓ G47582

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Lafayette and John Sts
(c) Hospital or institution Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Timonium
(If outside city or town limits, write RURAL and give town)
(d) Street No. Lafayette & John Streets
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby FOWBLE (Boy)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 7, 1947

8. AGE: Years 0 | Months 0 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Carroll Fowble
13. Birthplace Texas, Maryland

MOTHER
14. Maiden Name Norma Louise Miller
15. Birthplace Baltimore, Md.

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 17, 1947 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Maryland

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Md.

19 (a) JAN 16 1947 (Date received by Registrar) (b) Thomas J. Williams, M.D. Registrar

VS 3

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 1947, at 4:58 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 7 1947 to Jan. 15 1947 and that I last saw him alive on Jan. 15 1947.

Immediate cause of death Respiratory Failure — Duration 10 hrs.

Due to Aspiration

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James N. McCosh M.D.
Address Women's Hospital Date signed 1/15/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47583

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48 B

Registered No. G47583

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 824 E. 33rd St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-3
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 824 E. 33rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary F. Baur

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife J. Fred. Baur
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7-1880

8. AGE: Years 66 | Months 9 | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER 12. Name Henry Feike
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Mary E. Busick
15. Birthplace Balto. Md.

16 (a) Informant J. Fred. Baur
(b) Address 824 E. 33rd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount,
Location Greenmount Ave.

18 (a) Funeral director John A. Ingram
(b) Address 4201 Greenmount Ave

19 (a) ____ (b) Washington Blvd.

JAN 16 1947

V S 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 15th 1947; at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1946 to Jan 15 1947, and that I last saw her alive on Jan 14 1947.

Immediate cause of death Carcinoma uteri — Duration 2 yrs 1 mo

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation Feb and Oct 1944
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George S. Lahey M. D.
Address 432 N. Calhoun St. Date signed 1/16/47

G17584

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 47D

Registered No. G17584

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: River + Carolina
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 20 days
(e) Length of stay in Baltimore (yrs., mos., or days): 45 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: Md (b) County: Anne Arundel
(c) City or town: Millersville
(If outside city or town limits, write RURAL and give town)
(d) Street No.: Box 138 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

**3 (a) FULL NAME:** Joseph F. KAISER

3 (b) If veteran, name war: —
3 (c) Social Security Account No.: —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife: Barbara
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9/14/1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 4 | 2 | hr. min. |

9. Birthplace: Germany (Town, county and state)
10. Usual Occupation: Engineer (Stationery)
11. Industry or business: Dept of Education Bel Air City

| | |
|---|---|
| FATHER | 12. Name: Mathias Lauer |
| | 13. Birthplace: Bavaria Germany |
| MOTHER | 14. Maiden Name: Anna Weber |
| | 15. Birthplace: Bavaria Germany |

16 (a) Informant: Mrs Joseph F Kaiser
(b) Address: Millersville Md R.F.D. Box 138

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan 20 1947 (month) (day) (year)
(c) Cemetery or crematory: Glen Haven
Location: Glen Burnie, Md

18 (a) Funeral director: Thomas W. Templeton
(b) Address: Glen Burnie, Md

19 (c) JAN 16 1947 Registrar Millersville, Md

## MEDICAL CERTIFICATION

20. DATE OF DEATH: January 16 1947, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/26 1946, to 1/16 1947, and that I last saw h.i.m. alive on 1/16 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure due to | |
| Due to Pulmonary Hemorrhage due to | |
| Due to Pneumonia, Lobar due to | |
| Other Conditions Long Coma | |

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation: Pulmonary Hemorrhage
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Richard H. Young M. D.
Address: St. Josephs Hosp. Date signed 1/16/47

VS 150

X

G47585

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G47585
Registered No.

# CERTIFICATE OF DEATH 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 5 days
(e) Length of stay in Baltimore (yrs., mos., or days): 5 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: Pa. (b) County:
(c) City or town: Philadelphia
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 336 E. Tulpehocken St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

**3 (a) FULL NAME:** Denisof, Alexis

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. 186-14-9730 |
|---|---|

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife: Madeline Severac Denisof
6 (c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): Feb. 11, 1893

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | 11 | 4 | hr. min. |

9. Birthplace: Moscow, Russia (Town, county, and state)
10. Usual Occupation: 2nd mate
11. Industry or business: Seafarer

FATHER
12. Name: Seymour Denisof
13. Birthplace: Russia

MOTHER
14. Maiden Name: Anna Youdin
15. Birthplace: Russia

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof: 1/16/47 (month) (day) (year)
(c) Cemetery or crematory
Location: Germantown, Pa.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md

19 (a) JAN 16 1947 (Date filed by registrar) (b) [signature] Registrar

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH: Jan. 15 1947 at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1947 to Jan. 15 1947. And that I last saw him alive on Jan. 15 1947

| Immediate cause of death | Duration |
|---|---|
| Coronary sclerosis with occlusion and myocardial infarction | UNKNOWN |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy: As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed:

VS 150

G47586

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 51 B

G47586 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 927 Washington Blvd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 927 Washington Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** PHILIP HENRY METZGER, SR.

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 216-07-6403

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widower |

6 (b) Name of husband or wife: Anna Metzger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1869

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 7 | 29 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Cabinet Maker

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Dorothy Franks
(b) Address 2309 Allendale Rd. 16

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JAN 16 1947 (Date rec'd by registrar) (b) [illegible]

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 15, 1947, at 11:30P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1946 to Jan 15 1947 and that I last saw h. alive on Jan 14 1947.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma Prostate Gland | 1 yr |
| Due to | |
| Due to | |
| Other Conditions Pyelonephritis | 4 mos |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John P. Ulrich Jr. M. D.
Address 1222 Wash. Blvd. Date signed 1/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47587

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 97

G47587 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Oliver & Caroline
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Baltimore 24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2911 Dillon St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Thomas E Bowling

3 (b) If veteran, name war —

3 (c) Social Security Account No. ✓

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/12/1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 8 | 4 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Waterman

11. Industry or business Baltimore City

FATHER
12. Name R Bowling
13. Birthplace St Mary County Md

MOTHER
14. Maiden Name Eliz. Sullivan
15. Birthplace ?

16 (a) Informant Mary Bowling
(b) Address 2911 Dillon St

17 (a) Burial (b) Date thereof 1-20-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director Bernard Hayle
(b) Address 1000 S Paca St

19 (a) JAN 16 1947 (b) [illegible] Williams, M.D.
Registrar

VS 190

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 16 1947; at 12.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/ 1947 to 1/16 1947, and that I last saw him alive on 1/16/47 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardio - Respiratory Failure | |
| Due to Arteriosclerosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard N. Young M. D.

Address St. Joseph's Hosp. Date signed 1/16/47

X

G47588 BALTIMORE CITY HEALTH DEPARTMENT G47588
Registered No.

# CERTIFICATE OF DEATH

507765 56E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Va. (b) County
(c) City or town Winchester
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 Euclid Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Thomas A. Boyce

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-22-46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 26 | hr. min. |

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Boyce
13. Birthplace W. Va.

MOTHER
14. Maiden Name Madge Hupp
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 1/18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sam. - Mt. Pleasant
Location Winchester Va.
18 (a) Funeral director Laurence Jones.
(b) Address Winchester Va.
19 (a) (b)
(Date received by registrar)

JAN 20 1947
Informant — James E. Boyce

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 16 1947 at 4.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan - 9 1947 to Jan - 16 1947 and that I last saw h. alive on Jan 16 - 1947

Immediate cause of death
Post operative Shock
following operative Hem. 20 days
Due to abdominal Tumor
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 1-11-47
Major findings of operation: Mesenteric cyst & ? Duplication ileum
of autopsy: Serious Renewed Suppuration Lung

Duration: 9 days; 20 days; year

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature D. S. Joggs M. D.
Address Johns Hopkins Hospital Date signed 1-16-47

G47589

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D ✓

Registered No. G47589

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 827 N. Collington Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-13
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 827 N. Collington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Levy

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Frank Levy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1856

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 90 | 2 | - | hr. min. |

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Shrha
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace Czechoslovakia

16 (a) Informant Mrs. Kathryn Marlowe - daughter
(b) Address 827 N. Collington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison St.

JAN 16 1947 (Local registrar) Huntington Williams M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 13 1947, at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1944 to Jan 13 1947 and that I last saw h[illegible] alive on Jan 13 1947.

| | Duration |
|---|---|
| Immediate cause of death: Coronary Occlusion | 1/11/47 |
| Due to Chr Myocarditis | Jan 1944 |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address 801 N Kenwood Date signed 1/14/47

X

G47590

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G47590

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706 Mc Henry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs. Catherine Woods

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife Louis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26 - 1901

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 45 | 5 | 21 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Himes
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Holter
15. Birthplace Md.

16 (a) Informant Louis Woods
(b) Address 706 Mc Henry St

17 (a) Burial (b) Date thereof Jan 20/47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Cemetery or crematory Brunswick
Location Washington County Md.

18 (a) Funeral director Jabez Dailey
(b) Address Brunswick Maryland

19 (Date received by registrar) JAN 16 1947 Washington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-16 1947, at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6 1947 to 1-16 1947. and that I last saw h CK alive on 1-16 1947.

| | Duration |
|---|---|
| Immediate cause of death Multiple Small Cerebral Infarctions | 3 days |
| Due to Hypertensive Cardio-Vascular Heart Dis. | 5-7 yrs. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John C. Morrison M. D.
Address Univ. Hosp. Date signed 1-16-47

X

G47591 BALTIMORE CITY HEALTH DEPARTMENT G47591

# CERTIFICATE OF DEATH

Registered No. 12/a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1216 E. North Avenue
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 E. North Avenue
(If Rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Frederick Coleman

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 716-03-1009

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mildred C. Wilkinson
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) April 29, 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 8 | 16 | ##### min. |

9. Birthplace Church Hill, Maryland (Town, county, and state)
10. Usual Occupation Telegrapher (Operator)
11. Industry or business Penns. R. R.

FATHER
12. Name William Coleman
13. Birthplace Church Hill Maryland

MOTHER
14. Maiden Name Martha Anderson
15. Birthplace Church Hill Maryland

16 (a) Informant Mrs. Mildred C. Coleman
(b) Address 1216 E. North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 18, 1947 (month) (day) (year)
(c) Cemetery or crematory Morelands Park
Location Taylor Avenue, Balto: Co

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) JAN 16 1947 (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 15, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1944 to Jan 15 1947. and that I last saw alive on Jan 15 1947

Immediate cause of death: Cardiac Insufficiency
Uremia

Due to Hypertension

Due to

Other Conditions Chr. Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: a 2

**PHYSICIAN**
Underline the causes to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 1216 E North Ave Date signed 1/15/47

VS 150

Birth Certificate

G-67879

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

159

Registered No. G-7592

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Dukeland & Ramsay
(c) Hospital or institution: W. Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3018 Pinewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles Gregory Scott

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | W | |

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 6 | hr. min. |

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Scott
13. Birthplace Penna.

MOTHER
14. Maiden Name Mary Inwald
15. Birthplace Balto. Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JAN 16 1947
18 (a) Funeral director Commissioner of Health
(b) Address
19 JAN 16 1947 (Date Rec'd by Registrar) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 14 1947, at 1:45 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 1-8 1947, to 1-14 1947 and that I last saw him alive on 1-14 1947

Immediate cause of death: Atelectasis — Duration
Due to:
Due to:
Other Conditions Prematurity
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Atelectasis bilateral

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. A. Treptow M. D.
Address W. Balto Gen Hosp Date signed 1-15-47

VS 150

G47593

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 47D

G47593 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct race is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 114 E. Clement St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or Town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 E. Clement St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** George H. Deck

3 (b) If veteran, name war 1 st
3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Marie T. Deck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 6. 1890

8. AGE: Years 56 | Months 1 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business Southern Canning Co.

FATHER 12. Name Henry Deck
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Mary Eisel
15. Birthplace Baltimore Md

16 (a) Informant Marie T. Deck
(b) Address 114 E. Clement St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-1947 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. G. Co. Md.

18 (a) Funeral director Flippin & Flaying
(b) Address 1496 Light St.

JAN 17 1947 (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 1/14 1947, at 2:30 A. M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1927, to 1/13 1947, and that I last saw h[illegible] alive on 1/13 1947.

Immediate cause of death Carcinoma Rt. Lung — Duration not definitely known

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23. Signature** [signature]

Address 107 E. West St Date signed 1/16/47 M. D.

VS 180

G47594

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

937

G47594
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1602 Light St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 Light St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Vincenza Faro

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Joseph Faro

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26 1865

8. AGE: Years 81 | Months 7 | Days 20 | If less than one day: hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation

11. Industry or business Housework

FATHER — 12. Name John Reina
13. Birthplace Italy

MOTHER — 14. Maiden Name Antonia LaPrama
15. Birthplace Italy

16 (a) Informant Miss Grace Faro
(b) Address 1607 Light st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-18-1947 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Flynn & Fleming
(b) Address 1476 Light St.

(Date rec'd by registrar) JN 17 1947 (Signature of Registrar) Wellington Williams M.D. Registrar

VS 186

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Jan. 15 - 1947, at 3:40 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from 1/12 1947 to 1/15 1947, and that I last saw her alive on 1/15 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral hemorrhage severe | 3 days |
| Due to Hypertension Cerebral Vascular Disease | 20 Yrs (Estimated) |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23. Signature** E Freeman M.D.

Address 107 E. West St Date signed 1/16/47

X

G17595

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1310

Registered No. G17595

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1425 Hull St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40
(e) Length of stay in Baltimore (yrs., mos., or days) 59

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1425 Hull St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Flynn

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| ✓ | ✓ |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | Widowed |

6 (b) Name of husband or wife Michael J. Flynn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 2 69 | — | — | hr. min. |

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Patrick O'Hara
13. Birthplace Ireland

MOTHER
14. Maiden Name Agatha Kane
15. Birthplace Ireland

16 (a) Informant James Flynn (Son)
(b) Address 1425 Hull St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director Flynn & Flemming
(b) Address 1426 Light St.

JAN 17 1947 (Date received by local registrar) for Williams M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1947, at 12 50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21 1946 to June 13 1947 and that I last saw h.e alive on June 12 1947.

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia | 3d. |
| Nephritis | 5d. |
| Due to Cerebral Thrombosis | 7 years |
| Hypertension | 7 years |
| Due to Chronic Interstitial Nephritis | 7 years |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature J F A Stevens M. D.
Address 618 Hartford Rd Date signed 1-16-47

X

G47596

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G47596

CWK-107565

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 76- 7- 28-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 830 Hanover Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Joshua Houck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17-1870

8. AGE: Years 76 | Months 7 | Days 28 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles H. Houck
13. Birthplace Maryland

MOTHER
14. Maiden Name Louisa Dixon
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Frederick Md.

18 (a) Funeral director Wm Cook Inc
(b) Address 1317 St Paul St

19 (a) Date rec'd by local reg. JAN 17 1947 (b) Registered by Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 1947, at 12:40M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 13 1947 to Jan. 15 1947 and that I last saw h alive on Jan. 15 1947

Immediate cause of death Pulmonary Tbc. & Cavitation & Hemorrhage - Cf. — Duration

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert R. Fowler M. D.
Address Balto. City Hosp Date signed 1-15-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 150

G47597

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

G47597

Registered No. 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2901 Alameda Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2901 Alameda Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Annie L Reising

3 (b) If veteran, name war: W
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Julius A
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18 1864

8. AGE: Years 82 | Months 6 | Days 26 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Barnett
13. Birthplace England

MOTHER
14. Maiden Name Annie Bellis
15. Birthplace England

16 (a) Informant Estelle Elridge
(b) Address 2901 Alameda Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/17/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Wilson & Son Inc
(b) Address 1219 E Fort Ave
(c) Date rec'd by registrar JAN 17 1947

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** June 14 1947, at 5 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Sept. 5, 1946, to Jan. 14, 1947, and that I last saw her alive on Jan. 14, 1947.

| | Duration |
|---|---|
| Immediate cause of death: Uremia | 24 hrs. |
| Due to: Chronic Interstitial Nephritis | 5 yrs. |
| Due to: | |
| Other Conditions: Arteriosclerosis | 5 yrs. |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert G Finegerald M.D.
Address 1613 E. Northern Date signed 1-15-47

VS 150

G47598

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G47598 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 933 N Washington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 933 N Washington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Frederick Wiseman

3 (b) If veteran, name war No

3 (c) Social Security Account No. 219-14-0855

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth A.

6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Dec 4 1873

8. AGE: Years 73 | Months 1 | Days 3 10 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Night Watchman

11. Industry or business

FATHER 12. Name John Wiseman

13. Birthplace [illegible] Baltimore

MOTHER 14. Maiden Name Elizabeth Miller

15. Birthplace Baltimore Md.

16 (a) Informant Charles Wiseman

(b) Address 2609 E. Chase St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1/17/47 (month) (day) (year)

(c) Cemetery or crematory Mineland Mem. Pk.

Location Taylor Ave.

18 (a) Funeral director M. W. E. Riggel's Sons

(b) Address Lombard & Fremont Sts

JAN 17 1947 (Date received) [illegible] (Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 14 1947 at 2:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Jan 14 1947 and that I last saw him alive on Jan 13 1947

Immediate cause of death Coronary Artery Disease — Duration

Due to Generalized Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard Ball M. D.

Address 1221 N. Luzerne Ave Date signed Jan 15 1947

VS 150

G47599

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 183a

G47599 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 N. Pine St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME George A. OWNES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-14-1897

8. AGE: Years 49 | Months 2 | Days - | If less than one day .....hr. .....min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Alexander Owens
13. Birthplace Va

MOTHER
14. Maiden Name Clara Hayden
15. Birthplace Va

16 (a) Informant Mrs. Edna Owens
(b) Address 915 N. Arlington Ave

17 (a) Burial (b) Date thereof 1-18-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William J. Lambert
(b) Address 916 Pennsylvania Ave

JAN 17 1947 (b) Washington for Williams, M.D.
(Date rec'd by local registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 14, 1947 at 10.10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral hemorrhage
Pulmonary edema
Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature George C. Merrill M.D.
Medical Examiner.
Date signed 1/15/47

X

G47600

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1647

G47600 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lexington
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 W Lexington (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** HARRY FOARD

3 (b) If veteran, name war —

3 (c) Social Security Account No. 578-05-7593

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | W |

6 (b) Name of husband or wife Mary E. Lawson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 25, 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 2 | 19 | hr. min. |

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Ret. Boat Builder

11. Industry or business

FATHER
12. Name Henry O. Foard
13. Birthplace Md.?

MOTHER
14. Maiden Name Mary
15. Birthplace Del.

16 (a) Informant Family
(b) Address 1302 W. Lexington St

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 1-17-47 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount Ave.

18 (a) Funeral director J. H. McCurley
(b) Address 130 S. Fort Ave.

JAN 17 1947 (Date rec'd by Registrar) Registrar

VS 151

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan 14 1947 19 at 5:20 P.M.

**21.** I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shock

Due to Hemorrhage from stab wound of epigastrium

Other Conditions
Arteriosclerotic Cardiovascular Disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Jan 14 1947 at 4:45 P.M.
(b) Where did injury occur? 1302 W Lexington
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Self Inflicted Knife Cut

23. Signature Edward R. Curtis M.D.
Medical Examiner.
Date signed 1/15/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

47601

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1937

Registration No. 647601

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 370 S. Bruce St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 370 S. Bruce St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph M. Sabo

3 (b) If veteran, name war None

3 (c) Social Security Account No. 215-12-5509

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Johanna J. Sabo

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19-1885

8. AGE: Years 61 | Months 9 | Days 26 27 | If less than one day ____ hr. ____ min.

9. Birthplace Yugoslavia (Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business

FATHER 12. Name John Sabo
13. Birthplace Yugoslavia

MOTHER 14. Maiden Name Catherine —
15. Birthplace Yugoslavia

16 (a) Informant Johanna J. Sabo
(b) Address 370 S. Bruce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 18-1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Loch Raven Blvd & E.N. City Walters

18 (a) Funeral director Pratt Street Chapel
(b) Address

Filed JAN 17 1947 (Date received by Registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 15 1947, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to Jan 1947, and that I last saw him alive on Jan 12, 1947.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertensive C-V Disease

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herman H. Bayless M. D.

Address 1608 Wilkens Ave Date signed 16 Jan 47

X

G47602

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1248

Registered No. G47602

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2920 Brighton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** WILLIAM H. GEES

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | no |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Bertha M. Gees
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 6 | 11 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Supervisor
11. Industry or business Balto. Post Office

FATHER
12. Name Thomas B. Gees
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Amelia B. Garrett
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Bertha M. Gees
(b) Address 2920 Brighton St.

17 (a) Burial (b) Date thereof 1/18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Waugh M. E. Church Cem
Location Glen Arm, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received (b) Registrar

JAN 17 1947 Huntington Williams M.D.

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 1/16 1947, at 3 AM

**21.** I certify that death occurred on the date above stated; that I attended deceased from 1/15 1947 to 1/16 1947.
and that I last saw him alive on 1/16 1947.

Immediate cause of death HEMORRHAGE IN GASTRO INTESTINAL TRACT — Duration 1/2 DAY
Due to PORTAL AND BILIARY CIRRHOSIS
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy: PORTAL AND BILIARY CIRRHOSIS ESOPHAGEAL VARICES

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles W. Stewart, Jr. M. D.
Address MD. GENERAL HOSP. Date signed 1/16/47

X

G47603

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 194a

G47603 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3219 N Calvert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Bayer

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife: Gertrude W. Bayer (nee Foley)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1889

8. AGE: Years 57 | Months 0 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business: C. & P. Telephone Co.

FATHER
12. Name: Charles R. Bayer
13. Birthplace: Balto. Co.

MOTHER
14. Maiden Name: Katherine Karnorodt
15. Birthplace: Baltimore

16 (a) Informant: Mrs. Gerturde W. Bayer
(b) Address: 3219 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/20/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) Date rec'd by Registrar JAN 17 1947 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/16/47 at 3:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 1/16/47

VS 181

PRINT IN WHITE ISLAND, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47604 Registered No. 1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette Sts.
(c) Hospital or Institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1243 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** George Grap

3 (b) If veteran, name war —
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28, 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 3. | 19 | hr. min. |

9. Birthplace Baltimore.
(Town, county, and state)
10. Usual Occupation Laborer.
11. Industry or business

FATHER
12. Name Charles Grap
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Fopp
15. Birthplace Baltimore Md

16 (a) Informant Mrs Charles Grap
(b) Address 1243 W Fayette St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/47 (month) (day) (year)
(c) Cemetery or crematory St Pauls Cem.
Location Edmondson Ave
18 (a) Funeral director John Conlon & Son
(b) Address 207-09 Gallows St
(c) Date received by registrar JAN 17 1947 (d) Signature of registrar

VS 189

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16 1947 at 10 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 12/31 1946, to 1/16 1947, and that I last saw him alive on 1/16 1947.

Immediate cause of death: Lobar Pneumonia — Duration 5 days
Due to
Due to
Other Conditions Pulmonary Tuberculosis ? Hemiplegia, Hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward H. Southwick M. D.
Address Franklin Sq. Hosp Date signed 1/16/47

605

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 97

Registered No. 647605

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 302 S. Gilmor St
(c) Hospital or institution
19-

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 302 S. Gilmor St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Cloud L. Norris

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| male | white | Widower |

6 (b) Name of husband or wife Late Louise V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29, 1862

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 84 | 3. | 18 17 | hr. min. |

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Painter-Hardwood finisher
11. Industry or business Retired

FATHER
12. Name Jesse L. Norris
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Mary Ann Hoecker
15. Birthplace York, Pa

16 (a) Informant Mr. George Norris
(b) Address 302 S. Gilmor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-18-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director John J. Lannon & Son
(b) Address 901-03 Hollins St.

19 JAN 17 1947 (b) [illegible]
(Date received by local registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 16 1947, at 6.14 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1947 to Jan 16 1947 and that I last saw him alive on Jan 13 1947

Immediate cause of death: uremia —
Due to
Due to
Other Conditions: generalized arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: Interval

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathan Ransom M. D.
Address 206 S. Gilmor St. Date signed 1-17-47

G17606

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1312

Registered No. G17606

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4340 Falls Road.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4340 Falls Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Robert E. Creswell.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Johanna T. Creswell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 2, 1863

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 3 | 12 | hr. min. |

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Retired.
11. Industry or business

FATHER
12. Name John Creswell.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Mary ?
15. Birthplace Maryland.

16 (a) Informant Mrs. Johanna T. Creswell.
(b) Address 4340 Falls Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 17/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn.
Location

18 (a) Funeral director Schnauffer & Sonneborn
(b) Address 3615-17 Christmont Ave

19 JAN 17 1947 (Date accepted by Registrar) Hamilton Williams, M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 14 19 47 at 10.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 19 47 to Jan 14 19 47 and that I last saw him alive on Jan 13 19 47.

Immediate cause of death Bronchopneumonia — Duration

Due to Enteroptosis — C-V-13 Dis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward L. Hartman M. D.
Address 937 Eutaw Pl Date signed 1/16/47

X

G17607

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G17607

Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 616 Park Avenue
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 616 Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SUSAN (HOFFS) Wolf (SUSANNA (WOLFE) Wolf

3 (b) If veteran, name war No

3 (c) Social Security Account No. None

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 3 | | hr. min. |

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Wolf
13. Birthplace Germany

MOTHER
14. Maiden Name Genevie ?
15. Birthplace Germany

16 (a) Informant Mrs. Irvin A. Rick
(b) Address 1925 Oakhill Avenue

17 (a) Burial (b) Date thereof 1/18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Baltimore, Md

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY
(a) (Date rec'd by registrar) JAN 17 1947 Registrar Williams, M.D.

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/16/47 19 , at 8:45 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John F. Weaver M.D.
Medical Examiner.
Date signed 1/16/47

G47608

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 163H

G47608 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 6109 Tramore Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6109 Tramore Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** (Evelyn T. Wilson) Evelyn T. Wilson

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | 212-03-6490 |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife Melvin Wilson
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) Feb. 5, 1910

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 36 | 11 | 8 | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Ret. 7yr-C+P.Td. Co.

FATHER
12. Name Lawrence Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Winter
15. Birthplace Baltimore, Maryland

16 (a) Informant Mr. Melvin Wilson
(b) Address 3109 Tramore Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-17-47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

JAN 17 1947 (Date rec'd by Registrar) Hunter Williams M.D. Registrar

VS 131

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/13 1947, at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxia due to Illuminating gas
Due to
Other Conditions Dependency
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/13/47 at about 9:00 A.M.
(b) Where did injury occur? 6109 Tramore Rd
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Gas escaping from gas range

23. Signature C. L. Sherman M.D.
Medical Examiner.
Date signed 1/13/47

G17609

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46F

Registration No. G17609

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 150 N Luzerne Ave
(c) Hospital or institution: Pine Ridge Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 150 N Luzerne Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Anna Catherine McCabe

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife William McCabe
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) April 3. 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 9 | 11 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business At home

FATHER
12. Name John Kipp
13. Birthplace Baltimore

MOTHER
14. Maiden Name Catherine Hunter
15. Birthplace Baltimore

16 (a) Informant William McCabe
(b) Address 150 N Luzerne

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 17th (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

JAN 17 1947 (Date rec'd by registrar)

(b) [illegible] M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 1947, at 4:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 9th 1946, to Jan 13th 1947 and that I last saw h[illegible] alive on Jan 13th 1947.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of liver | 2 |
| Due to General metastasis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H J Tenkin M. D.
Address 100 N Luzerne Date signed 1/17/47

V S 150

G17610

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. G17610

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St.
(c) Hospital or institution:
St. Josephs Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 D
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 829 E. Chase St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ellen M. (Nellie) Lavery

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-6387

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13 1884

8. AGE: Years 62 | Months 4 | Days 3 | If less than one day hr. min.

9. Birthplace Eastern Md.
(Town, county, and state)

10. Usual Occupation Buyer, May Co.

11. Industry or business Dept. Store

FATHER 12. Name Robert Lavery

13. Birthplace Ireland

MOTHER 14. Maiden Name Ann McKernan

15. Birthplace Ireland

16 (a) Informant Mr. Bernard Lavery

(b) Address 4209 Ivanhoe Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 20/47 (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cemetery

Location Harford Rd at Broadway

18 (a) Funeral director Daniel W. Coughlin & Son

(b) Address 924 E. Eager St.

JAN 17 1947 (Registered by Registrar) (b) Kenneth Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/16/1947, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11/47 to 1/16/47 and that I last saw her alive on 1/15/1947

Immediate cause of death: Cardiorespiratory failure — Duration

Due to: Sub-arachnoid Hemorrhage

Due to: Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard W. Young M. D.

Address St. Josephs Hosp. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G47611

G47611

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 125 N. Dallas St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 125 N. Dallas St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Vernell Collins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: April 3, 1904

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/3/1904

8. AGE: Years 42 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Richmond Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Richard Shearon
13. Birthplace N. C.

MOTHER
14. Maiden Name Delia Gaitts
15. Birthplace Va.

16 (a) Informant: Gabbie Shearon
(b) Address 125 N. Dallas St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 17 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Chas O. Wilson
(b) Address 1510 Orleans St

JAN 17 1947 (Date rec'd by Local Registrar) Hamilton Williams M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

1/13/47 10:00 PM

20. DATE OF DEATH Jan. 13 1947, at 10:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-23 1946, to 1-13 1947, and that I last saw h.e alive on 1-13 1947.

| | Duration |
|---|---|
| Immediate cause of death: Apoplexy of brain | 2 wks |
| Due to: Hypertension | 1 yr. |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. M Daniel M. D.
Address 907 N. Caroline St Date signed 1-11-47

X

G47612

BALTIMORE CITY HEALTH DEPARTMENT ✓ G47612

# CERTIFICATE OF DEATH 170c

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County 2
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 S. Exeter St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Antones Maurrello

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) ?

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | | | hr. min. |

9. Birthplace ? (Town, county, and state)

10. Usual Occupation ?

11. Industry or business ?

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant ?
(b) Address ?

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 18 1947 (month) (day) (year)
(c) Cemetery or crematory Balto N.S. National
Location Balto.

18 (a) Funeral director F.V. Pipitone
(b) Address 2820 E Balto St.

19 (a) JAN 17 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 14, 1947, at 12.10 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry (Autopsy, Inspection or Inquiry), find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of 2nd & 3rd Cervical vertebrae
Multiple fractures

Due to

Other Conditions Subarachnoid Hemorrhage
Bonier.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-13-47 at 11.47 p. M. 11/2
(b) Where did injury occur? Howard St. near Preston St.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Pediastrian struck by auto

23. Signature Howard J. Mullen M.D. (Medical Examiner.)
Date signed 1-14-47

VS 151

correct age is especially important. Physicians: please write the ... items, ... information should be carefully supplied. The ... the causes of death clearly and legibly.

G47613

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

Registered No. G47613

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 809 S. Eaton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 6
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 809 S. Eaton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** John Loeffler

3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-01-6165

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M. | W. | Married |

6 (b) Name of husband or wife Mary Loeffler
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) 8-21-1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 4 | 23 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Bricklayer.
11. Industry or business Hathaway-Patterson Co.

FATHER — 12. Name John Loeffler
13. Birthplace Germany

MOTHER — 14. Maiden Name Mary Wachter
15. Birthplace Germany.

16 (a) Informant Mary Loeffler (wife)
(b) Address 809 S. Eaton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave. & Rd.

18 (a) Funeral director Charles S. Zeiler
(b) Address 3605 Fait Ave.

19 JAN 17 1947 Registrar Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-14 1947, at 8.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 11 1947 to Jan 14 1947, and that I last saw h[illegible] alive on Jan 14 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | |
| Due to Hypertension - Cardio Vascular Disease | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. A. J. Lamajan M.D.
Address 3503 Fait Ave Date signed Jan 17 47

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

647614

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

124B

Registered No. 647614

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 538 W Conway St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 530 W. Conway St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ethel Lee Ross

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Col. | Married |

6 (b) Name of husband or wife Granville

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1897

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 49 | 7 | 8 | hr. min. |

9. Birthplace Florida
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15 Birthplace

16 (a) Informant Granville Ross
(b) Address 530 W. Conway

17 (a) Burial (b) Date thereof 1-18-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Mt. Wilson

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 332 N. Schroeder St

19 JAN 17 1947 Huntington Williams M.D.
(Date received by registrar)

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/15 1947 at 6-15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1946 to 1/15 1947 and that I last saw h[illegible] alive on 1/15 1947

Immediate cause of death Hypertrophic Cirrhosis of Liver — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: 0

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Franklin M. D.
Address 1 W 4 Ser Date signed 1/17/47

G17615

CWK- 107515

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

137a

Registered No. G17615

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 Years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1649 Barnes Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20-1883

8. AGE: Years 62 | Months 1 | Days 25 | If less than one day ____hr. ____min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Henry Lee

13. Birthplace ?

MOTHER 14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 18, 1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St

19 (a) JAN 17 1947 (b) Registrar
(Must not be filled in by registrar)

V S 150

Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 1947, at 8:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 11 1947 to Jan. 15 1947, and that I last saw h. im alive on Jan. 15 1947.

Immediate cause of death (a) Pyelonephritis — Duration 1 weeks

Due to Benign Hyperplasia of Prostate with complete urinary obstruction

Due to

Other Conditions Cystitis, pyelitis, cholangitis cholecystitis, pulmonary edema, uremia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Above

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice M. Levy M. D.

Address Baltimore City Hospitals Date signed 1-16-47

X

G47616

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G47616

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 804 W. Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 804 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John R. White

3 (b) If veteran, name war None | 3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Mary A. White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1850

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 96 | — | 22 | hr. min. |

9. Birthplace Walbrook Baltimore Md. (Town, county, and state)
10. Usual Occupation Laborer (Retired)
11. Industry or business Woolen Mill

FATHER
12. Name Richard White
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Unknown

16 (a) Informant Mrs. Robert Brooke
(b) Address 804 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 18, 1947 (month) (day) (year)
(c) Cemetery or crematory White Family
Location Oella, Md.

18 (a) Funeral director Easton Sons
(b) Address Ellicott City, Md.

19 (a) [illegible] Registrar

JAN 17 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15, 1947 at 12:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1938 to Jan 15 1947 and that I last saw h.i.v. alive on Jan 14 1947

| Immediate cause of death | Duration |
|---|---|
| Myocardial Degeneration | 9 yrs. |
| Due to Senility | 10 yrs. |
| Due to — | |
| Other Conditions — | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: No

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. Floyd Johnson M. D.
Address Catonsville Date signed 1/16/47

G47617

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 97

Registered No. G47617

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 510 W Hamburg St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 510 W Hamburg St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fredrick Moog

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1860

8. AGE: Years 87 | Months | Days | If less than one day hr. min.

9. Birthplace: Baltimore (town, county, and state)

10. Usual Occupation: Retire

11. Industry or business

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Edith Gracely
(b) Address 510 W Hamburg St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director Bernard Hoile
(b) Address 1000 S. Paca St

19 (Signature of local registrar) JAN 17 1947 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-17-47 19 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1-46 19 to 1-17-47 19 ; and that I last saw h[illegible] alive on 1-17-47 19

| | Duration |
|---|---|
| Immediate cause of death: Stomach Bronchial pneumonia | |
| Due to Arteriosclerosis, chronic. | 4-5 yr |
| Due to | |
| Other Conditions | |
| (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. D. Boyle M.D.
Address 642 North Rd Date signed 1-17-47

VS 150

X

G17618

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G17618 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 227 N Fulton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 d
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 227 N Fulton Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary H Rawlings

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | W. |

6 (b) Name of husband or wife J. P. J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4 1861

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 85 | 8 | 12 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Benjamin Fowler
13. Birthplace Md

MOTHER
14. Maiden Name Eliza J Esaex
15. Birthplace Md

16 (a) Informant Mrs Edw Burns
(b) Address 227 N Fulton Ave

17 (a) Burial (b) Date thereof 1-19-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Asylum Cem
Location Frmst Fred. Md.

18 (a) Funeral director Jorge A Tinley
(b) Address Fulton & Fayette

19 (a) Filed (b) JAN 17 1947 Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 16 1947, at 9-4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1946, to Jan 16 1947, and that I last saw h.e alive on Jan 14 1947

Immediate cause of death Pulmonary Oedema

Due to Chronic Myocarditis

Due to

Other Conditions Nephritis Senilis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

| Duration |
|---|
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James H Colquhoun M. D.
Address 721 Medical Arts Date signed 1/17/47

G47619

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G47619

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3413 Paton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3413 Paton Ave, (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lottie Stillman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5 Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Isaiah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1891

8. AGE: Years 55 | Months 3 | Days 28 | If less than one day: hr. min.

9. Birthplace New Bedford, Mass. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Watts
13. Birthplace Mass.

MOTHER
14. Maiden Name Emma Lee
15. Birthplace Mass.

16 (a) Informant Isaiah Stillman
(b) Address 3413 Paton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 16, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Chas. H. Hulland
(b) Address 1617 Druid Hill Ave.

JAN 17 1947 (date rec'd by registrar) (b) Registrar

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan 15 1947, at 4:45 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from Nov 14 1946, to Jan 15 1947, and that I last saw her alive on Jan 15 1947.

| | Duration |
|---|---|
| Immediate cause of death Cardio Vascular Disease | 24 hrs |
| Due to Pulmonary Edema | 2 days |
| Due to Hypertension | 3 yrs |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23. Signature** E. Williams Fley M. D.
Address 1924 Eutaw St. Date signed 1/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G17620 ✓ G17620

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 B

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution:
Provident Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore 23
(If outside city or town limits, write RURAL and give town)
(d) Street No. 337 W. Biddle St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Radcliffe

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Negro | Widowed |

6 (b) Name of husband or wife MARY RADCLIFFE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 10 | 29 | hr. min. |

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business ICE

FATHER
12. Name Thomas Radcliffe
13. Birthplace N. Carolina

MOTHER
14. Maiden Name ?
15. Birthplace N. CAROLINA

16 (a) Informant MRS. BERTHA WALKER
(b) Address 1508 E. Biddle St.

17 (a) Burial (b) Date thereof JAN. 17-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ ARBUTUS MEM. PK.
Location BALTIMORE Co. Md.

18 (a) Funeral director J. L. PRESTON & INBERRY
(b) Address 519 Mosher St.

19 JAN 17 1947 Thurlington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 186

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 14 1947, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17 1946, to 1-14 1947, and that I last saw h.i.m alive on 1-14 1947.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of Stomach (pylorus) | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Barnes M. D.
Address Broadway Hospital Date signed 1/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47621

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G47621

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1700 Park ave
(c) Hospital or institution:
Wheeler Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 John St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Elizabeth Morris Bond

**3 (b) If veteran, name war**

**3 (c) Social Security Account No.**

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F. | W. | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 29 1849

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 97 | 1 | 18 | hr. min. |

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas E. Bond
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Morris
15. Birthplace Md

16 (a) Informant Emily O Taliaferro
(b) Address Baldwin Md

17 (a) Burial (b) Date thereof Jan 18 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address McCulloh & Orchard Sts

JAN 17 1947

19 (a) (b)
(Date rec'd by Registrar) Registrar

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan 16 1947 at 6 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from June 1936 to Jan 16 1947
and that I last saw her alive on Jan 16 1947

Immediate cause of death
Myocarditis
Arterio-Sclerosis

Duration
Unknown

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature W H Grady, M.D.
Address 1403 Park Ave Date signed 1/17/47

X

617622

CWK-107488

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13B

Registered No. 617622

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 735½ W. Saratoga Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Sam Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | ? |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15, 1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | ? | 27 | hr. min. |

9. Birthplace Not Known
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace

MOTHER
14. Maiden Name Not Known
15. Birthplace

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/15/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto Md

18 (a) Funeral director Isaiah L Broughton
(b) Address 1080 Monument St

19 (Signature of local registrar) JAN 17 1947 Registrar
Huntington Williams, MD

V S 150

## MEDICAL CERTIFICATION

A

20. DATE OF DEATH January 11 1947, at 11:40M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1947, to Jan. 11 1947, and that I last saw h. alive on Jan. 11 1947.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Tuberculosis, Far Advanced | 1 yr ? |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Refused

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Hurst M. D.
Address Balt City Hospitals Date signed 1-14-47

G47623 ✓ G47623

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 130

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 147 W. Montgomery St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ronald Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Negro | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1940

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 6 | 9 | 29 | hr. min. |

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Danny
13. Birthplace

MOTHER
14. Maiden Name Willie - Scott
15. Birthplace Baltimore Md

16 (a) Informant Robert Caldwell
(b) Address 147 W Montgomery St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-18-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary C
Location E. A. Co. Md

18 (a) Funeral director Isaiah L. Brewington
(b) Address 104 W Montgomery St

JAN 17 1947 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** January 15th 1947, at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-2 1947 to Jan 15 1947, and that I last saw him alive on Jan 15 1947

| Immediate cause of death | Duration |
|---|---|
| Due to Acute Nephritis | 7 days |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hendelcom M. D.
Address 1751 Harlem Date signed 1/15/47.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47621

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G47624

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7 N. Chapel St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** HENRY HESS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10-186

8. AGE: Years 79 | Months 4 | Days 2 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Handy Man.

11. Industry or business

FATHER
12. Name John Hess
13. Birthplace German

MOTHER
14. Maiden Name N K Hess
15. Birthplace N K Hess

16 (a) Informant Margaret Pittmer
(b) Address 20 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 17-47 (month) (day) (year)
(c) Cemetery or crematory St. Matthews Lawn
Location E. Donnell St.

18 (a) Funeral director John A. Keller
(b) Address 2334 Jefferson St.

19 JAN 17 1947 (month) (day) (year) Huntington Williams M.D.

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan. 12 1947, at 11:25 P. M.

**21.** I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic heart disease

Due to Bronchopneumonia

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrell M.D. Medical Examiner.
Date signed 1/13/47

VS 151

G47625

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

Registered No. G47625

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp. 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 hours
(e) Length of stay in Baltimore (yrs., mos., or days) 68 years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 137 North Kenwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** SELTZER JOSEPH WASHINGTON SELTZER

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | MARRIED |

6 (b) Name of husband or wife DAISY SELTZER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/30/1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 0 | 17 | hr. min. |

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation JUDGE
11. Industry or business

FATHER
12. Name ADAM SELTZER
13. Birthplace MD.

MOTHER
14. Maiden Name MARY WOOLFORD
15. Birthplace MD.

16 (a) Informant Mrs. J. W. Seltzer
(b) Address 137 N. Kenwood Ave

17 (a) Burial (b) Date thereof 1 20 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto. Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 2401 Alain Pl.

19 (a) JAN 17 1947 Washington Williams, M.D.
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 17 1947, at 4:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1947 to Jan 17 1947, and that I last saw h[illegible] alive on Jan 17 1947.

| Immediate cause of death | Duration |
|---|---|
| Diabetes mellitus | |
| Intestinal obstruction | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman Jr. M. D.
Address Union Memorial Hosp Date signed Jan 17, 1947

VS 150

G417626

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 45F

✓ Registered No. G417626

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 124 days
(e) Length of stay in Baltimore (yrs., mos., or days) 124 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State NY (b) County
(c) City or town Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 147 Columbia St. (If rural give location)
(e) Citizen of foreign country? Filipino (Yes or No)
If yes, name country

**3 (a) FULL NAME** Romero, Igmidio Isturis

3 (b) If veteran, name war

3 (c) Social Security Account No. 086-12-8522

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Esther Okoa Romero
6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | 5 | 10 | ...hr. ...min. |

9. Birthplace Banga Capic, PI (Town, county, and state)
10. Usual Occupation Chief steward
11. Industry or business Seafarer

FATHER
12. Name Bonifacio Romero
13. Birthplace Banga Capic, PI

MOTHER
14. Maiden Name Eusloquia Isturia
15. Birthplace Banga Capic, PI

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-47 (month) (day) (year)
(c) Cemetery or crematory Bend Heart
Location Lorman Miss Rd.

18 (a) Funeral director Lyles Funeral Home
(b) Address 403 S. Wolfe, St.

19 JAN 17 1947 (Date received by local registrar) (b) Huntington Williams, Md.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 15 1947, at 4 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 13 1946, to Jan. 15 1947, and that I last saw him alive on Jan. 15 1947.

Immediate cause of death Carcinoma of nasopharynx with extension to skull and right cerebello-pontine angle region of brain. — Duration UNKNOWN

Due to — Duration over

Other Conditions Otitis media, suppurative acuter. Ulcer of right cornea
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ...at... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 1/17/47

VS 150

X

G47627

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G47627

47a

1GD 105009

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 - 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Coldspring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Thomas Moynihan

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 1 | — | hr. min. |

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
Industry or business

FATHER
12. Name Daniel
13. Birthplace Ireland

MOTHER
14. Maiden Name Johanna Rouch
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Ave

18 (a) Funeral director Feldy + Zieler Inc
(b) Address 403 S. Eutaw St.

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by reg.) JAN 17 1947

V S 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 9 1947, at 1:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 4 1946, to Jan. 9 1947, and that I last saw him alive on Jan. 9 1947

Immediate cause of death: Carcinoma of Larynx — Duration 6 Mos

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 12/18/46

Major findings of operation: as above

of autopsy: Yes - as above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.
Address Balt. City Hosp. Date signed 1/17/47

X

G47628

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G47628

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4636 Pall Mall Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4636 Pall Mall Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** James M. McCrudden

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-5012

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Almeda Sharpe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 0 | 21 | hr. min. |

9. Birthplace Ariz.
(Town, county, and state)

10. Usual Occupation
11. Industry or business American Telephone Co.

FATHER
12. Name Johnny McCrudden
13. Birthplace Ireland

MOTHER
14. Maiden Name Kathleen Cowley
15. Birthplace Ireland

16 (a) Informant Mrs. Alma E. McCrudden
(b) Address 4636 Pall Mall Rd.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-18-47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director Sorrell Byers
(b) Address 5405 York Rd. Baltimore, Md.

19 JAN 17 1947 (Date rec'd by registrar) (b) Registrar Washington, Md.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 15, 1947 at 10 P. M. STD

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1946 to Jan 15 1947, and that I last saw him alive on Jan 15 1947.

Immediate cause of death: Coronary Thrombosis — Duration 1 day

Due to Arteriosclerosis

Due to Senility

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sherlock J. Wells M. D.
Address 5276 York Rd. Baltimore Date signed Jan 17, 47

VS 150

G47629 BC 46519

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 107

Registered No. G47629

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: SINAI HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 dy
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 828 LIGHT ST.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

**3 (a) FULL NAME** Arnold Edward Cudnik

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| — | — |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| MALE | WHITE | CHILD |

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4/29/46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 8 | 17 | hr. min. |

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name WILLIAM CUDNIK
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name SOPHIA BOGDAN
15. Birthplace BALTIMORE, MD.

16 (a) Informant MRS. SOPHIA CUDNIK
(b) Address 828 S. LIGHT ST.

17 (a) BURIAL (b) Date thereof 1/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS
Location MT. CARMEL ROAD.

18 (a) Funeral director M. J. Pacholski & Son.
(b) Address 806 Eastern Ave.

19 (Date rec'd by registrar) JAN 17 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 16 1947 at 10:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15, 1947 to Jan 16 1947 and that I last saw h alive on Jan 16, 1947

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Bronchopneumonia | |
| Due to | |
| Other Conditions Tracheostomy | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sidney Green M.D.
Address Sinai Hospital Date signed 1/16/47

VS 150

647630

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48 B

Registered No. 647630

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 402 Lyman Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 Lyman Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lelma Virginia Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Thomas L Johnson Sr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19 1903

8. AGE: Years 44 | Months 8 | Days 25 | If less than one day hr. min.

9. Birthplace Maryland
(town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wm Seelenberg

13. Birthplace Maryland

MOTHER 14. Maiden Name Lottie Addison

15. Birthplace Penn

16 (a) Informant Mr Thomas L Johnson Sr.

(b) Address 402 Lyman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 18 1947 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location 3801 Frederick Ave

18 (a) Funeral director Henry H Wirth

(b) Address 4101 Edmondson Ave

JAN 18 1947 (b) Huntington Williams, M.D.

VS 190

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 14 1947, at 7.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 31 1945 to Jan. 14 1947 and that I last saw her alive on Jan. 14 1947

Immediate cause of death: Broncho-pneumonia — Duration 2 days

Due to Carcinoma Uterus — Aug 1945

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl H Zerbe, M.D.

Address 5111 York Rd Date signed Jan 15, 1947

M. D.

X

G47631

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 48a

G47631 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: Lombard & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1662 Wakema Rd (If rural give location) Wakema
(e) Citizen of foreign country? Md (Yes or No)
If yes, name country

**3 (a) FULL NAME** Agnes Arnold

3 (b) If veteran, name war | (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | M |

6 (b) Name of husband or wife James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14 1912

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 44 | 11 | 3 | hr. min. |

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business

FATHER
12. Name John Gerale
13. Birthplace Austria

MOTHER
14. Maiden Name Anna Bacha
15. Birthplace Austria

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (b) Date thereof 1/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Yeadon, Pa.

18 (a) Funeral director John F. Dickman & Son
(b) Address 1 N. Pine

JAN 18 1947 (Date rec'd by registrar) Hamilton Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/17 1947, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27 1946, to 1/17 1947
and that I last saw h.e.r alive on 1/17 1947.

Immediate cause of death Uremia

Due to Carcinoma of Cervix
Due to with metastasis to Abdominal

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Cervix
of autopsy: Squamous cell Carcinoma

| Duration |
|---|
| 1 1/2 years |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James S. Hunter, Jr. M. D.
Address University Hospital Date signed 1/17/47

VS 150

X

BG 17632 BG# G67279 BALTIMORE CITY HEALTH DEPARTMENT G47632 Registered No. 107

# CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto 16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2700 N. Howard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Mary Ellen Shaneybrook

3 (b) If veteran, name war: W
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, ~~married, widowed,~~ or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age ~ years
7. Birth date of deceased (mo., day, yr.) Jan 7th 1947
8. AGE: Years | Months | Days: 10 | If less than one day: hr. min.
9. Birthplace Balt. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

**FATHER**
12. Name Edward C. Shaneybrook
13. Birthplace Cockeysville Md.

**MOTHER**
14. Maiden Name Ellen Bostwick
15. Birthplace Balto. Md.

16 (a) Informant Edward C. Shaneybrook
(b) Address 2700 N. Howard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/20/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul Huntington Williams, M.D.

19 (a) JAN 18 1947 (Date received by Registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 17th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1947 to Jan 17 1947 and that I last saw h~~er~~ alive on Jan 15 1947

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Bronchial pneumonia | |
| Due to | |
| Other Conditions Malnutrition | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William F. Cook M. D.
Address Bon Secours Hosp. Date signed 1/19/47

VS 150

G47633

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

832

Registered No. G47633

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 6000 Belloma Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 12
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2911 St Paul St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna C Ryan

3 (b) If veteran, name war: W
3 (c) Social Security Account No. 212-[illegible]-3251

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Wid
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec 14 1877

8. AGE: Years: 69 | Months: 9 | Days: 3 | If less than one day: hr. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual Occupation: Laborer
11. Industry or business: Public Institution

FATHER
12. Name: James A Ryan
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Mary Carroll
15. Birthplace: Ireland

16 (a) Informant: Miss Agnes Gannon
(b) Address: 4807 E 31st St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1/20/47 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore Md

18 (a) Funeral director: Tilyou & Lee
(b) Address: 1217 St Paul St

19 (a) [illegible] (b) Huntington Williamsport Md

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 17 1947 at 2 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940 to Jan 16 1947 and that I last saw h[illegible] alive on Jan 16 1947

Immediate cause of death: cerebral Thrombosis — Duration: 2 hours

Due to: Arteriosclerosis — 2 years

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Gilbert H. Wortman Jr. M.D.
Address 2706 St Paul St Date signed 1/17/47

VS 150

G17631

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 63c

G17634 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County —
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 730 E. 37th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Margaret Denny

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: DEDF

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Single |

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 9th 1903

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 43 | 3 | 8 | hr. min. |

9. Birthplace Balto - Md. (Town, county, and state)
10. Usual Occupation Telephone Operator
11. Industry or business U. S. Govt

FATHER:
12. Name George A. Denny
13. Birthplace Balto. Md.

MOTHER:
14. Maiden Name Jennie Davis
15. Birthplace Balto. Md.

16 (a) Informant Isabelle Denny (Sister)
(b) Address 730 E. 37th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/21/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

JAN 18 1947 (Date rec'd by registrar) (b) Registrar Hampton Williamitis, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 17th 1947, at 11:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 1947 to 1/17 1947 and that I last saw h.C.V. alive on 1/17 1947

| | Duration |
|---|---|
| Immediate cause of death: Massive Pulmonary Edema | 12 hrs. |
| Due to: Congestive Heart Failure Grade IV | 6 days |
| Due to: Acute Postarior Myocardial Infarction | 7 days |
| Other Conditions: Pneu. Hypothyroidism | 2-3 yrs. |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B. Marmon M. D.
Address Univ. Hosp. Date signed 1/17/47

X

G47635

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G47635 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2416- Frederick Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALMA LORETTA SCHNUR

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: HNF

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~: Joseph Schnur
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 27th 1887

8. AGE: Years 59 | Months 1 | Days 20 | If less than one day hr. min.

9. Birthplace Cumberland Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name John Paulus
13. Birthplace Md.

MOTHER
14. Maiden Name Anna (Unknown)
15. Birthplace Md.

16 (a) Informant William A. Bailey
(b) Address 8125 Bull Neck Road

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 1/20/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 JAN 18 1947 (Date rec'd by local Reg.) by [illegible] for Williams M.D. (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17, 1947 at 10.25 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 1/17/47

VS 151

C47636

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1316

Registered No. C47636

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 830 S. Sharp St.
(c) Hospital or institution: mu
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days) —

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 830 S. Sharp St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Marshall

3 (b) If veteran, name war mu

3 (c) Social Security Account No.

4. Sex male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Georgia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 61 yrs. | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation mother

11. Industry or business

FATHER 12. Name Samuel Marshall

13. Birthplace Md.

MOTHER 14. Maiden Name Sarah Marshall

15. Birthplace Md.

16 (a) Informant Mrs. Georgia Lawson

(b) Address 137 W. Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 20-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Jas. A. Stamus

(b) Address 1642 W. Fayette St

19 Filed JAN 18 1947 by Hunter Williams M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16 1947, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 28 1946 to Jan. 16 1947 and that I last saw h alive on Jan. 15 1947

Immediate cause of death Apoplexy — Duration 3 days

Due to Bronco Pneumonia

Due to Chronic Nephritis — 2 mos.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Shelton M. D.

Address 908 S. Sharp St Date signed 1-17-47

G47637 BG# G49755 BALTIMORE CITY HEALTH DEPARTMENT X 119a Registered No. G47637

# CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Raynor & Dukeland
(c) Hospital or institution: The Bay to Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Parkville (If outside city or town limits, write RURAL and give town)
(d) Street No. 8307 old Harford Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Francis Jager

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 7 | 3 | hr. min. |

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles C. Jager
13. Birthplace Md

MOTHER
14. Maiden Name Doris L. Leight
15. Birthplace Md

16 (a) Informant Mr. Charles C. Jager
(b) Address 8307 old Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-19-47 (month) (day) (year)
(c) Cemetery or crematory Moreland Pk Cem
Location Balto. Co. Md.
18 (a) Funeral director Leonard J. Rusk
(b) Address 5305 Harford Rd
19 JAN 18 1947 Thurlington Wilson, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 17 January 1947 at 1:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 18 Nov 1946 to 17 Jan 1947 and that I last saw h[illegible] alive on 16 Jan 49 47

| Immediate cause of death | Duration |
|---|---|
| Resp. Failure | |
| Due to Pneumonia, bilateral | |
| Due to | |
| Other Conditions Diarrhoea ? etc | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lester G. Hall Jr. M.D.
Address U.S. Gen Hosp. Date signed 1/17/47

VS 150

G47638

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G47638

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 441 Rosebank Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 441 Rosebank Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ELSIE LINDEMORE HOCKADAY

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | no |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Frank Hockaday
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 6 | 24 | hr. min. |

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William H. Arthur
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah A. Jackson
15. Birthplace Md.

16 (a) Informant Mr. Frank Hockaday
(b) Address 441 Rosebank Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/47 (month) (day) (year)
(c) Cemetery or crematory Govans Presby. Cem.
Location Govans, Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 JAN 18 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15, 1947, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1941 to Jan 15 1947 and that I last saw h[illegible] alive on Jan 10 1947.

| Immediate cause of death | Duration |
|---|---|
| Arteriosclerosis - | 1947 |
| Chron Myocarditis | 1945 |
| Due to Acute Cardiac Dilatation | 1947 |
| Due to | |
| Other Conditions Hyp. Chr. Nephritis | 1945 |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature G. H. Bishop M. D.
Address 503 S Linden Ave Date signed Jan 7-47

VS 150

G17639
CWK-107331

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH
555

Registered No. G17639

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 E. Pratt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Louis Schmidt

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Mary E. May
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1858

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 88 | | | hr. min. |

9. Birthplace ?
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Mary ?
15. Birthplace

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1/18/47 (month) (day) (year)
(c) Cemetery or crematory WOODLAWN
Location
18 (a) Funeral director CLARENCE F. HOFFMANN
(b) Address 1697 BROADWAY
19 Filed JAN 18 1947 (b) Registrar Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 16 1947, at 4:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5 1947, to Jan. 16 1947, and that I last saw h in alive on Jan. 16 1947.

Immediate cause of death Carcinomatosis — primary site undetermined — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Robinson Jr. M. D.
Address Balt. City Hosp. Date signed 1/17/47

V S 150

G17640

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G17640 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3418 Elliott St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 6
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3211 Elliott St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Amelia M. Nitscher

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | W |

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 0 | 19 | hr. min. |

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation house wife
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Germany

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant Mrs. Arthur Coleman
(b) Address 3418 Elliott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/18/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (Date received by registrar) JAN 18 1947 Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/16/1947 at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11 3 1947 to 1/16 1947 and that I last saw h[illegible] alive on 1/14 1947.

Immediate cause of death: Chronic myocarditis & decompensation — Duration 13 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. Father F. Hoffmann M. D.
Address 1016 S. East Ave. Date signed 1/16/47

VS 150

647611

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

463

Registered No. 647611

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State md. (b) County Montgomery
(c) City or town Dickerson
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Samuel Wayne

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | white | married |

6 (b) Name of husband or wife Rebecca
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-23-98

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 48 | 8 | 23 | hr. min. |

9. Birthplace md. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Samuel Wayne
13. Birthplace md

MOTHER
14. Maiden Name Mollie Insel
15. Birthplace md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-47 (month) (day) (year)
(c) Cemetery or crematory Koontz Chapel
Location Near Dickerson, Md.
18 (a) Funeral director M. R. Etchison & Son
(b) Address Frederick, Md.
19 (a) JAN 18 1947 (b) Registrar, Washington, D. C.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 16 1947, at 9.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9 Jan 1947 to 16 Jan 1947, and that I last saw him alive on 16 Jan. 1947

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure | 3 mos. |
| Malnutrition | |
| Due to Carcinoma of | |
| stomach, ? metastases | 16 mos |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 14 Nov 46
Major findings of operation: carcinoma of stomach
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Paul Huggins, M. D.
Address Johns Hopkins Hospital Date signed 1-20-47

G17642

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1310

Registered No. G17642

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2029 Orleans St
(c) Hospital or institution: 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2029 Orleans St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Bertha Feldwein

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John Feldwein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/21/1857

8. AGE: Years 89 | Months 10 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county and state)

10. Usual Occupation
11. Industry or business At Home

FATHER 12. Name Dont Know
13. Birthplace Germany

MOTHER 14. Maiden Name Dont Know
15. Birthplace Germany

16 (a) Informant Mrs Elizabeth Heldine
(b) Address 1741 Jackson St

17 (a) Burial (b) Date thereof Jan 20 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Carmel Cem
Location Catty

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2005 Orleans St

19 (a) JAN 18 1947 (b) Signature and title of registrar Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 17 1947, at 12:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/30 1946 to 1/17 1947; and that I last saw h[er] alive on 1/16 1947.

Immediate cause of death
Sec. Colon Obstruction — Duration 2 Days
Due to Chronic Enlargement of Prostate
Due to Chronic Nephritis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hugh L. Riddle
Address 3373 E. Baltimore St Date signed 1/19/47

V S 150

G17613

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1314

Registered No. G17613

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2711 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town 2711 Edmondson Ave. (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore Md. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Schad

3 (b) If veteran, name war: No

3 (c) Social Security Account No. ?

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lula E. Schad

6 (c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): March 23, 1877

8. AGE: Years: 69 | Months: 9 | Days: 24 | If less than one day: hr. min.

9. Birthplace: Martinsburg West Virginia (Town, county, and state)

10. Usual Occupation: Machinist

11. Industry or business: Sparrows Point

FATHER
12. Name: John H. Schad
13. Birthplace: Martinsburg West Virginia

MOTHER
14. Maiden Name: Ella Jackson
15. Birthplace: Martinsburg West Virginia

16 (a) Informant: Mrs. Lula E. Schad
(b) Address: 2711 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1/20/47 (month) (day) (year)
(c) Cemetery or crematory: Western
Location: Baltimore

18 (a) Funeral director: Geo. W. Little
(b) Address: 2700 Edmondson Ave.

19 (a) JAN 18 1947 (Registrar's signature) Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16 1947, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1946 to Jan 16 1947.
and that I last saw h[illegible] alive on Jan 16 1947.

Immediate cause of death: Coronary thrombosis
Interarteriosclerotic typ[illegible] heart disease
with cardiac hypertrophy + dilatation
Due to failure + Generalized arteriosclerosis with hypertension
Due to
Other Conditions Chronic Pyelonephritis + Prostatitis.
Duodenal ulcer.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

Duration: Hours.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: W Murchil M. D.
Address 2901 Edmondson Ave. Date signed Jan 16 1947

G17644

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46E

G17644 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Rutherford St
(c) Hospital or institution: West Baltimore Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 528 N. Decker St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Mrs. Alma Chance
3 (b) If veteran, name war —
3 (c) Social Security Account No.
4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married
6 (b) Name of husband or wife Thomas Roy Chance | 6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 19 1893
8. AGE: Years 53 | Months 8 7 | Days 29 | If less than one day — hr. — min.
9. Birthplace Hurlville Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Isaac Jacobs
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Priscilla McKenna
15. Birthplace Phila. Pa.

16 (a) Informant Thomas R. Chance
(b) Address 528 N. Decker Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Rd.
18 (a) Funeral director John F. Miller Sons
(b) Address 243 E. Oliver St
19 JAN 18 1947 Baltimore, Md.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 17 January 1947, at 12:45 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 1 Jan 1947, to 17 Jan 1947, and that I last saw her alive on 17 Jan 1947

| | Duration |
|---|---|
| Immediate cause of death Respiratory Failure | |
| Due to Pulmonary Infarction | |
| Due to Pulmonary Thrombosis | |
| Other Conditions Intestinal Obstruction Caused by Large Bowel Cancer | |

(Include pregnancy within 3 months of death)
Date of operation 4 Jan 47
Major findings of operation: Intestinal obstruction; Tumor of Large Bowel
of autopsy: —

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury
23. Signature B. Robert Hardy M.D.
Address West Balt. Gen'l Hosp. Date signed 17 Jan 47

G47645

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

116

Registered No. G47645

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age in especially important. Physicians; please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Fairland & Green
(c) Hospital or institution: Univ. Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State W. Va. (b) County
(c) City or town Charleston
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rt 3. Box 599 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beatrice M. Edwards

3 (b) If veteran, name war

3 (c) Social Security Account No. -

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1923

8. AGE: Years 23 | Months 7 | Days 16 | If less than one day hr. min.

9. Birthplace Charleston, W. Va. (Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER
12. Name O. G. Edwards
13. Birthplace Leon, W. Va.

MOTHER
14. Maiden Name B. M. Childress
15. Birthplace Quincy, W. Va.

16 (a) Informant O. G. Edwards.
(b) Address Charleston, W. Va.

17 (a) Transportation (Burial, cremation, or removal) (b) Date thereof 1/18/47 (month) (day) (year)
(c) Cemetery or crematory Sunset Memorial Park
Location Charleston, W. Va.

18 (a) Funeral director Howard M. Bligh Jr.
(b) Address 4914 Belair Road

19 (a) Filed JAN 18 1947 (b) Huntington Williams, M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-18-47 1946, at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-2 1947 to 1-18 1947 and that I last saw h.e.r. alive on 1-15 1947.

Immediate cause of death Resp. failure — Duration

Due to Pneumonitis

Due to Post-operative

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1-15-47

Major findings of operation Stenosis of esophagus

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Vaughan Jr. M. D.
Address Univ. Hospital Date signed 1-18-47

G17646

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1316

Registered No. G17646

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 910 W. Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 910 Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Georgiana Sprow
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race Col
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Samuel Sprow
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sep. 1884
8. AGE: Years 62 Months 4 Days If less than one day hr. min.
9. Birthplace West River Md (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Richard Wells
13. Birthplace West River Md

MOTHER
14. Maiden Name Rachel Johns
15. Birthplace West River Md

16 (a) Informant Samuel Sprow
(b) Address 910 W. Fayette St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 19, 1947 (month) (day) (year)
(c) Cemetery or crematory Laurel Cem.
Location
18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 222 N. Schroeder St.
19 JAN 18 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jany 16, 1947 at 11 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 1-9-1947 to 1-16-1947 and that I last saw her alive on 1-16-1947.

| | Duration |
|---|---|
| Immediate cause of death Congestive Heart Failure | |
| Due Chronic Myocarditis and Chronic Nephritis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. F. Rozell M. D.
Address 601 N. Carrollton Ave signed 1/17/47

VS 150

G17647

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G17647

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1320 Sheldon Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1320 Sheldon Avenue (If institutional location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ida Ellen (Nellie) Sullivan

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 19-1871

8. AGE: Years 75 | Months 10 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore Co. Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name William Henry Sullivan
13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Jane Miller
15. Birthplace Maryland

16 (a) Informant Mrs. Bessie Garner
(b) Address 1320 Sheldon Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 18-1947 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 JAN 18 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 16- 1947, at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1946 to Jan 16 1947, and that I last saw h[illegible] alive on Jan 16 1947.

Immediate cause of death Cerebral Hemorrhage — Duration 20 days.

Due to Chronic nephritis — Duration

Due to Hypostatic pneumonia. — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Sullivan
Address [illegible] 3687. Date signed 1/18/47.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 17618 / 131a

17618

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 416 W. Saratoga St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 416 W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MIRIAM VERONICA BROWN

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1914

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 32 | 7 | 17 | hr. min. |

9. Birthplace Chambersburg, Pa. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business National Biscuit Co.

FATHER
12. Name Harry E. Brown
13. Birthplace Coatesville, Pa.

MOTHER
14. Maiden Name Agnes Veronica Webb
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Harry E. Brown
(b) Address 416 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/20/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JAN 18 1947 (Date rec'd by registrar) (c) Huntington Williams, M.D.

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH Jan. 16, 1947 at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944 to 16 Jan 1947
and that I last saw h[illegible] alive on 16 Jan 1947

Immediate cause of death [illegible] Duration 2 hr
Due to [illegible] 1 yr
Due to [illegible] 2 yrs
Due to [illegible] 3 yrs.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry J. Crowley M.D.
Address 115 E. Eager St. Date signed 1/17/47

VS 150

G47619

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 52B

G47619 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 227 E. North Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 227 E. North Ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** Robert W. Beach, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Virginia Benson
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) March 26, 1869

| 8. AGE: | Years | Months | Days | If less than one day |
|---|---|---|---|---|
| | 77 | 9 | 22 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation lawyer
11. Industry or business

FATHER
12. Name William H. Beach
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary E. Flannigan
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Virginia B. Beach
(b) Address 227 E. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/20/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ New Cathedral
Location Edmondson Ave., Baltimore

18 (a) Funeral director John C. Mitchell's Sons, Inc.
(b) Address 1900 Eutaw Place

JAN 18 1947 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** January 17 1947 at 4.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1920 to Jan 17 1947 and that I last saw h[illegible] alive on Jan 17 1947

Immediate cause of death (a) Carcinoma metastases + Lymphosarcoma — Duration 3 months
Due to (b) Carcinoma of Bladder — Duration 4 years
Due to (c) — Duration
Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert M. Foster M. D.
Address 2824 St. Paul St. Date signed

VS 150

X

G17650

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 54B

Registered No. G17650

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3106 Glenmore Ave.
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3106 Glenmore Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Elizabeth Nostrand Carvel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Arnold W. Carvel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1885

8. AGE: Years 62 | Months 6 | Days 25 24 | If less than one day hr. min.

9. Birthplace Brooklyn, N. Y.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Peter Elbert Nostrand
13. Birthplace New York

MOTHER
14. Maiden Name Ella F. Arcularius
15. Birthplace N. Y.

16 (a) Informant Mrs. Arnold W. Carvel
(b) Address 3106 Glenmore Ave.

17 (a) Burial (b) Date thereof 1/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Baltimore
Location North Ave. & Hilton Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

JAN 18 1947 (b) Thurlington Williams, M.D.
(Date received by Registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 17 1947, at 1120 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1946 to Jany 17 1947 and that I last saw her alive on Jany 17 1947

Immediate cause of death: Pulmonary Oedema — Duration: Jany 15/47
Due to:
Due to:
Other Conditions: Cerebral Tumor (Metastatic Carcinoma) — Nov 1946.
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature Morris B. Green M. D.
Address 3009 Evergreen Ave. Date signed 1/18/47

VS 150

Baltimore 14 Md. X

G47651 BC# B55643 G47651

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mo.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 421 N. Gilmore St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Macea Dumont Dyson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: B | 6 (a) Single, married, widowed, or divorced: S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1946

8. AGE: Years | Months: 4 | Days: 10 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name John Dyson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rosalie Marshburn
15. Birthplace North Carolina

16 (a) Informant Rosalie Dyson
(b) Address 421 N. Gilmore St. Bal.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 18 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore Md.

18 (a) Funeral director Chas. H. Alexander
(b) Address McCullough-Hiett. Huntington-Williams, Mgrs.

19 (a) JAN 18 1947 (Date rec'd by registrar) (b) Registrar

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-15 1947, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-14 1947, to 1-15 1947 and that I last saw h[illegible] alive on 1-15 1947.

| | Duration |
|---|---|
| Immediate cause of death: Respiratory failure | |
| Due to: Bronchopneumonia | |
| Due to: Pertussis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Marcy E. McMillan M. D.
Address Sydenham Hosp. Date signed 1-16-47

G17652

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 186a

Registered No. G17652

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 237 S. Ann St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Madejski

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | white | married |

6 (b) Name of husband or wife Joseph Madejski
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Dec 8 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 1 | 8 | hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Michael Kulinski
13. Birthplace Poland

MOTHER
14. Maiden Name Julia Dziarska
15. Birthplace Poland

16 (a) Informant Mr. Joseph Madejski
(b) Address 237 S. Ann Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location Baltimore County

18 (a) Funeral director John M. Webb
(b) Address 401 S. Chester St.

19 (a) Filed JAN 18 1947 by (b) Undertaker Williamsburg, Md.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-16 1947, at 4:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11 1947, to 1-16 1947, and that I last saw her alive on 1-16 1947.

Immediate cause of death: Pulmonary Embolism

Due to: Phlebothrombosis

Due to:

Other Conditions: Fracture L Tibia
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Pulmonary Embolism

| Duration |
|---|
| |
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 2/2
(a) Accident, suicide, or homicide accidental
(b) Date of occurrence 1-10-47 at ? M
(c) Where did injury occur? 237 S. Ann St.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? no
(Specify type of place)
(e) Means of injury fell down flight of steps

23. Signature E. F. Weisman M. D.
Address Sinai Hosp Date signed 1-16-47

Homer S. Mendes, M.D.

G17653

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G17653

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1733 E. Oliver Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1733 E. Oliver St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** WILLIAM ROLLE HART

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | 213-10-7974 |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Catherine L.
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) June 19, 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 34 | 8 | 27 | ....hr. ....min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Local Union Rep.

FATHER
12. Name Sampson Hart
13. Birthplace Germany

MOTHER
14. Maiden Name Anne Rolle
15. Birthplace Maryland

16 (a) Informant Mrs. Catherine L. Hart
(b) Address 1733 E. Oliver Street

17 (a) Burial (b) Date thereof 1/18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 JAN 18 1947 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 18 1947, at 2.15 A.M. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1947 to Jan 16 1947 and that I last saw h.. alive on Jan. 16 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 5 days |
| Due to Hypertensive Cardiovascular disease | 12 yrs. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 6217 Holford Rd Date signed 1/19/47 M.D.

VS 150

G17654 Birth Certificate 6838

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V159

Registered No. G17654

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wilkens + Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town 320 E. 26th St. Baltimore - 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Rafferty

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-17-47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | 12 hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Clewell Rafferty
13. Birthplace

MOTHER
14. Maiden Name Doris Akers
15. Birthplace Md.

16 (a) Informant MR. RAFFERTY
(b) Address 320 E. 26th ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-18-47 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL -
Location CITY

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT AVE & 22ND ST

19 (a) JAN 18 1947 (Date rec'd by registrar) Courtenay for Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17 1947, at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17 1947 to 1-17 1947, and that I last saw him alive on 1-17 1947

| Immediate cause of death | Duration |
|---|---|
| (a) Cardiac failure - maintaining | |
| Premature infant | |
| Due to (b) | |
| Due to (c) | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. N. Mintzer M.D.
Address Same Date signed 1/18/47

VS 150

G47655

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1362

Registered No. G47655

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 503 S Ann St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Baltimore Northeast
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7907 Westmoreland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Joseph Wozniacki

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Helen Wozniacki
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | — | — | hr. min. |

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Lorenz Wozniacki
13. Birthplace Poland

MOTHER
14. Maiden Name M. Zaczek
15. Birthplace Poland

16 (a) Informant Helen Wozniacki
(b) Address 7907 Westmoreland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 20/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Fred W Ozazewski
(b) Address 930 Eastern Ave

19 (a) JAN 18 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16 1947, at 1140 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1946, to Jan. 16 1947, and that I last saw him alive on Jan. 16 1947.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary hemorrhage | |
| Due to Chronic T.B. Bilateral | 5 months 5 days |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles L. Nieratdt M. D.
Address 1730 Linden Ave Date signed 1/17/47.

VS 150

X

G47656

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 97

G47656 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3811 Fairview Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3811 Fairview Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** C. ALICE GREENAWALT

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Thomas S. Greenawalt, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1858

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 88 | 4 | 24 | hr. min. |

9. Birthplace New Buffalo, Pa. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Michael Smith
13. Birthplace Pa.

MOTHER
14. Maiden Name ? Warner
15. Birthplace Pa.

16 (a) Informant Miss Mabel R. Greenawalt, Daughter
(b) Address 3811 Fairview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/20/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received by registrar 1/20 1947 (b) Washington Williams Registrar

VS 150

**MEDICAL CERTIFICATION** P.

20. DATE OF DEATH Jan. 17, 1947, at 1:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1947 to Jan. 17, 1947 and that I last saw her alive on Jan. 16, 1947.

| Immediate cause of death | Duration |
|---|---|
| Acute dilitation of heart | 2 days |
| Due to Advanced arterio-sclerosis | ? |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

23. Signature Walter E. Triblett M. D.
Address 2220 Harrison Blvd Date signed 1/18/47

5 G47657

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 43a

Registered No. G47657

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1616 E. Monument St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 E. Monument St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Catherine A. Dalhay

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charlie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 22, 1868

8. AGE: Years 78 | Months - | Days 24 | If less than one day hr. min.

9. Birthplace Easy. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Michael Queen
13. Birthplace Ind.

MOTHER
14. Maiden Name Mary Sheppard
15. Birthplace England

16 (a) Informant Catherine Dalhay
(b) Address Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 17 47 (month) (day) (year)
(c) Cemetery or crematory Arbutus M. Park
Location Arbutus Md.

18 (a) Funeral director Mrs. Pitt. G. Elliott Dpt
(b) Address 1129 N. Caroline St

Filed Jan 19 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 15 1947, at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1947 to Jan 15 1947 and that I last saw h.s.h. alive on Jan 15 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julius S. White M. D.
Address 1802 Penna Ave Date signed 1-17-47

VS 150

5[8] G47658 BALTIMORE CITY HEALTH DEPARTMENT G47658
Registered No.

# CERTIFICATE OF DEATH 1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1314 Division
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 Division St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Sarah B. Beckett

3 (b) If veteran, name war
3 (c) Social Security Account No. NONE

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1881

8. AGE: Years 65 | Months 3 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Edmonson Co. Virginia (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace

16 (a) Informant Mrs. Emma Johnson
(b) Address 1620 Division Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 19, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 631 Otterbein Ave. Baltimore, Md.

JAN 20 1947 (Date received by Registrar) (b) ... Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 16 1947, at 2 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27 1946, to 1-16-1947, and that I last saw h.a.c. alive on 1-16 1947.

Immediate cause of death: Congestive Heart Failure — Duration: 4 days
Due to Hypertensive Cardio-vascular Renal Disease
Due to Generalized Arterio-sclerosis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 1/18/47

VS 150

Death Certificate
Je 69348-647659

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH V161a

Registration No. C 47659

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 749 Dolphin St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Jeanne Sweet

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Negro | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 16, 1947

| 8. AGE: Years | Months | Days | If less than one day: hr. | min. |
|---|---|---|---|---|
| | | 1½ | | |

9. Birthplace Balto. Md.
(Town, county, and State)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Walter Sweet
13. Birthplace Wakefield Va.

MOTHER
14. Maiden Name Virginia Samuels
15. Birthplace Balto. Md.

16 (a) Informant Virginia Sweet.
(b) Address 749 Dolphin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 19, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Jno. Wm. Sl. Holland
(b) Address 1631 Druid Hill Ave.

JAN 19 1947 (Date received) (b) Huntington Williams, M.D. (Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 16, 1947, at 5:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1947, to Jan 16 1947, and that I last saw her alive on Jan 16, 1947.

| Immediate cause of death | Duration |
|---|---|
| (a) Atelectasis (Newborn) | 1 day |
| Due to (b) Prematurity | |
| Due to (c) | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jno. H. McDonald M. D.
Address 8 E 49th Casey Date signed 1/16/47

VS 150

G47660

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47660 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1831 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1831 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** George Washington Cosey

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-856

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1891

8. AGE: Years 56 | Months - | Days 6 | If less than one day hr. min.

9. Birthplace Gloucester, Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Collin Cosey
13. Birthplace Gloucester, Va

MOTHER 14. Maiden Name Lucy Booze
15. Birthplace Gloucester, Va

16 (a) Informant Mrs. Bernice Crawford
(b) Address 1831 Edmondson Ave.

17 (a) Burial (b) Date thereof Jan. 15, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Family Lot.
Location Gloucester, Va

18 (a) Funeral director Mrs. George A. Holland
(b) Address 1631 Druid Hill Ave.

AN (a) 1-9-1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-16-47 1947, at 4:52 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1947 to Jan 16 1947. and that I last saw h. alive on Jan 16 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julius S. White M. D.
Address 180 N Pennsa Date signed 1-18-47

VS 150

G47664 G47664

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 1937

Registered No. G47664

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3607 Mohawk Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3607 Mohawk Ave. 7
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** EVELYN TIMANUS

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife: Frank E. Timanus
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 23, 1857

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 89 | 3 | 24 | hr. min. |

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: John Albaugh
13. Birthplace: Germany

MOTHER
14. Maiden Name: Amelia White
15. Birthplace: England

16 (a) Informant: Mrs. H. E. Lyons
(b) Address: 3607 Mohawk Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/19/47 (month) (day) (year)
(c) Cemetery or crematory: Klines Grove Cem.
Location: Sunbury, Pa.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) JAN 19 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 17, 1947, at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 11, 1947 to Jan. 17, 1947 and that I last saw her alive on Jan. 16, 1947

| Immediate cause of death | Duration |
|---|---|
| Heart failure | 7 days |
| Due to Myocardial Degeneration with fibrillation | 7 days |
| Due to Senility with Arterio-Sclerosis | 7 |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Maurice E. Abrams M. D.
Address: 3200 W. Baltimore Date signed: 1-18-47

X

G17662 G17662

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: 1400 Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Penna. County Phila.
(c) City or town Philadelphia
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2112 Cross St. Phila.
(If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

**3 (a) FULL NAME** William H. Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | Colored | Married |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 10 | 23 | hr. min. |

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Godfrey Marlen
13. Birthplace Va

MOTHER
14. Maiden Name Martha Smith
15. Birthplace Va.

16 (a) Informant Sarah Martin
(b) Address 2112 Cross St Phila. Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 19 1947 (month) (day) (year)

(c) Cemetery or crematory
Location Philadelphia Pennsylvania

18 (a) Funeral director Mr Robt. A. Edwards Dft.
(b) Address 4129 N. Carolina St.

JAN 19 1947 (Date received by registrar) Huntington Williams, Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** January 16th 1947, at 7.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1947 to Jan 16th 1947 and that I last saw him alive on Jan 16 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardio Respiratory Failure | |
| Due to Cerebral Hemorrhage | |
| Due to Rupture of Rt cerebral artery | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry H. Waldman M. D.
Address 1st. Penna. Bldg. Date signed 1/16/47

VS 150

G47663

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47663 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1545 Augusta St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1545 Augusta St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Roy F. Bivens

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-3537

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1887

8. AGE: Years 57 | Months 9 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Helper Carpet

11. Industry or business Upholstery Storage

FATHER 12. Name Michael Bivens

13. Birthplace Washington Co Md

MOTHER 14. Maiden Name Elizabeth Hull

15. Birthplace Washington Co Md

16 (a) Informant Mary Lou Bivens

(b) Address 1545 Augusta St

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 1/21/47 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore Md

18 (a) Funeral director Tilburn & Son Inc

(b) Address 1317 E Pratt St

JAN (a) (Date rec'd by registrar) Huntington Williams Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 17 1947, at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1947 to Jan. 17 1947, and that I last saw her alive on Jan. 17 1947.

Immediate cause of death Arteriosclerotic C-V disease — Duration Hours

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Grenger M.D.

Address 1402 E Lanvale Date signed 1-19-47

X

G47664 G47664

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1900 N Washington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1900 N Washington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles A. Wagner

3 (b) If veteran, name war NA | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mamie A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1882

8. AGE: Years 64 | Months 10 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Tobacco

FATHER 12. Name Henry Wagner

13. Birthplace Germany

MOTHER 14. Maiden Name Margaret Miller

15. Birthplace Md

16 (a) Informant Mamie A Wagner

(b) Address 1900 N Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/21/47 (month) (day) (year)

(c) Cemetery or crematory Immanuel Lutheran

Location Baltimore Md

18 (a) Funeral director Wilson Cook Inc

(b) Address 1219 E Fayette St

JAN 19 1947 (b) Funeral to be held Registrar
(Registered by Registrar)

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Jan 18 1947, at 5:30 M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 13-May 1946, to 18-Jan 1947, and that I last saw h.i.m alive on 18-Jan 1947.

Immediate cause of death Coronary Occlusion — Duration 1 day

Due to Arteriosclerotic Cardio Vascular Disease — Duration May-46

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23. Signature** Chas W. Edwards M. D.

Address 2746 The Alameda Date signed 18-Jan-47

G47665

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47665 / 469

Registered No. G47665

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days): 36 days
(e) Length of stay in Baltimore (yrs., mos., or days): 9 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: Knights of Columbus Cathederal & Madison Sts.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

**3 (a) FULL NAME:** Hart, James Joseph

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 1, 1885

8. AGE: Years: 61 | Months: 7 | Days: 14 | If less than one day: hr. min.

9. Birthplace: Belfast, Ireland (Town, county, and state)
10. Usual Occupation: Chief engineer
11. Industry or business: Seafarer

FATHER
12. Name: James J. Hart
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Helen Barrett
15. Birthplace: Ireland

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/20/47 (month) (day) (year)
(c) Cemetery or crematory: St. Josephs
Location: Lynn Mass.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

19 (a) JAN 19 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Jan. 15 1947, at 6:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 10 1946 to Jan. 15 1947, and that I last saw him alive on Jan. 15 1947

Immediate cause of death: Carcinoma of head of pancreas with metatasis to liver and lungs — Duration: UNKNOWN
Due to:
Due to:
Other Conditions: Postoperative state cholecystojejunostomy & jejuno-jejunostomy — 2 days
(Pregnancy within 3 months of death)
Date of operation: 1-14-46
Major findings of operation:
Carcinoma of head of pancreas
of autopsy: As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed: 1/17/47

VS 150

X

G47666 BALTIMORE CITY HEALTH DEPARTMENT G47666
Registered No.

# CERTIFICATE OF DEATH 1467

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3017 Edmondson Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3017 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Annie L Tierney

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| W | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 24, 1869

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 1 | 22 | hr. min. |

9. Birthplace Philadelphia Pa
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Harry Young
13. Birthplace Philadelphia Pa

MOTHER
14. Maiden Name Maggie Lyhorn
15. Birthplace Philadelphia Pa

16 (a) Informant Mrs. L Schroffer
(b) Address 3017 Edmondson Ave

17 (a) Burial (b) Date thereof 1/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Md
18 (a) Funeral director Williams Cook Inc.
(b) Address 1217 St. Paul St.
19 (a) JAN 19 1947 (b) Huntington Williams, M.D.
(Date filed by Registrar) Registrar

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Jan 16 1947 at 10.30 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from December 20 1946 to Jan 16 1947, and that I last saw her alive on Jan 14 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | sudden |
| Due to Arteriosclerosis | |
| Cardio vascular Disease | 3 yrs. ± |
| Due to | |
| Other Conditions Carcinoma Rectum ± | 1 yr ± |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature J Karl Hamman M. D.
Address 1222 N. Patterson Pk Ave Date signed 1/21/47

G47667

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G47667 Registered No. 1131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1738 E Madison St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1738 E Madison St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Minnie C Frazier

3 (b) If veteran, name war W
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Charles H

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4 1872

8. AGE: Years 74 | Months 9 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Nuthall
13. Birthplace England

MOTHER 14. Maiden Name Sarah Hicks
15. Birthplace Maryland

16 (a) Informant Helen Frazier
(b) Address 1046 N Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/20/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Wilson & Lee
(b) Address 1947 Harford Ave

19 (a) JAN 19 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH (Month) July 16 (Day) 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 15 Jan 1947 to 16 Jan 1947, and that I last saw h alive on 16 Jan 1947

Immediate cause of death: Left Ventricular failure — Duration: 1 week
Due to: Cardio-vascular renal dis — Duration: ?
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Silverfield M.D.
Address 714 E Eutaw Date signed 1 Jan 47

VS 150

G17668

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 49a

G17668 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4208 Harford Road Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4208 Harford Road Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rosina L. DiDomenico

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 75 | 25 | hr. min. |

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Anthony DiDomenico
13. Birthplace Italy

MOTHER
14. Maiden Name Filippa Badale
15. Birthplace Italy

16 (a) Informant Joseph A. DiDomenico
(b) Address 5307 St. Albans Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 20. 47 (month) (day) (year)
(c) Cemetery or Location Holy Redeemer, Belair Road

18 (a) Funeral director Frank V. Pipitone
(b) Address 2818 E. Baltimore St.

JAN 19 1947 (Date rec'd by registrar) (b) Hamilton Town Williams Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-18 1947 at 1:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/44 1946 to 1/18 1947 and that I last saw h[illegible] alive on 1/15 1947.

Immediate cause of death: General Carcinomatosis — Duration

Due to Primary Carcinoma of Ovary

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Homeland M. D.
Address 33 Ampt Dr. Date signed 1/18/47

VS 150

G47669

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G47669 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3726 Chestnut Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3726 Chestnut Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary E. Dandy.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Samuel G. Dandy.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1859

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 87 | 8 | 29 | hr. min. |

9. Birthplace Virginia. (Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER
12. Name Richard Leonard.
13. Birthplace Virginia.

MOTHER
14. Maiden Name Jane Carr.
15. Birthplace Virginia.

16 (a) Informant Mary A. Markey.
(b) Address 3702 Elm Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 20/47 (month) (day) (year)
(c) Cemetery or crematory Stiltz,
Location Pennsylvania.

18 (a) Funeral director Kenneth Sowers
(b) Address 3615-17 Chestnut Ave

19 (a) JAN 19 1947 (Date received by Registrar) (b) Huntington Wallace, M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 17 1947, at 10 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to Jan 17 1947, and that I last saw her alive on Jan 15 1947

Immediate cause of death: Hypo-static Pneumonia — Duration 5 days

Due to: Chronic Cardio-Vascular disease.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M.D.
Address 1846 W 36 St - Date signed 1/17/47

X

G17670

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G17670
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital of inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Howard
(c) City or town Elliott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rogers Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Patsy Ann Jeates

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 10 | 1 | hr. min. |

9. Birthplace Ellicott City Md.
(Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name William Jeates
13. Birthplace N. C.

MOTHER
14. Maiden Name Hilda Mongold
15. Birthplace W Va.

16 (a) Informant William Jeates
(b) Address Ellicott City Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-21-47 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Ellicott City Md.

18 (a) Funeral director J C Nyi[illegible]sthorn
(b) Address Ellicott City Md

19 (a) [illegible]ington Williams, M.D. Registrar
(Date received) (Registrar)

JAN 19 1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-18 1947, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-28 1946 to 1-18 1947, and that I last saw her alive on 1-13 1947.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Tuberculous meningitis | |
| Due to Pulmonary tuberculosis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. B. Harley, M.D.
Address Union Hosp Date signed 1-18-47 M. D.

G47671 G47671

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 164c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Ehrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Catonsville Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Stoneall Park Rt 28
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Harry B. Dorsey

3 (b) If veteran, name war —

3 (c) Social Security Account No. ?

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Alberta Hawes Dorsey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10, 1910

8. AGE: Years 36 | Months 34 | Days 8 | If less than one day hr. min.

9. Birthplace Woodbine Md.
(Town, county, and state)

10. Usual Occupation Chauffeur
11. Industry or business

FATHER 12. Name Clyde Dorsey
13. Birthplace Md

MOTHER 14. Maiden Name Minnie E Shipley
15. Birthplace Md

16 (a) Informant Clyde Dorsey
(b) Address 79 Melon and Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-47 (month) (day) (year)
(c) Cemetery or crematory Morgan Chapel
Location Woodbine Md

18 (a) Funeral director F.C. Hej undertaker
(b) Address Ellicott City Md

19 (a) 1-18-1947 (Date rec'd by registrar) (b) Evelington for Williams M.D.

JAN 18 1947

VS 181

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 1/18 1947, at 2:40 P.M.

**21.** I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gunshot wound of head

Due to

Other Conditions Despondency
(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/17/47 at about 6 P.M.
(b) Where did injury occur? Stoneall Road-Rt 28
(c) Did injury occur at home, on farm, industrial place, in public place? State Highway While at work? No
(d) Means of injury Shot self in right temple

23. Signature R. J. Fulbrecht M.D.
Medical Examiner.
Date signed 1/18/47

G417672 G417672

BALTIMORE CITY HEALTH DEPARTMENT 1937 Registered No.

# CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: So Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37
(e) Length of stay in Baltimore (yrs., mos., or days) 58

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Dundalk,
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 21 Township Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daisy Black

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband ~~or wife~~ Charles L. Black
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/6/1889

8. AGE: Years 57 | Months 6 | Days 13 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jesse Fleckinger
13. Birthplace Md.

MOTHER
14. Maiden Name Carrie King
15. Birthplace Md

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 31 - 1947 (month) (day) (year)

(c) Cemetery or crematory Westminster Cem
Location Westminster Md

18 (a) Funeral director H. H. Hartman & Sons
(b) Address Union Bridge Md

19 (a) 1947 (State rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/19 19 47 at 3:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/14 1946 to 1/19 1947 and that I last saw h[illegible] alive on 1/9 1947

Immediate cause of death: Intracranial Hemorrhage
Due to Hypertensive Cardio Renal Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature R Carnefix
Address So Balto Gen Hosp Date signed 1/20/47

VS 150

G47673

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47673 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland — 2265 W.Baltimore St

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life.

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2265 W. Baltimore St.
(If rural give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

**3 (a) FULL NAME** FRANCIS R. GREENWOOD

3 (b) If veteran, name war: No.

3 (c) Social Security Account No. 214-01-5857

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Elsie L. Greenwood

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 6 | 25 | 24 hr. ********** min. |

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Brown Brothers

FATHER
12. Name Walter Greenwood
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Elsie L. Greenwood
(b) Address 2265 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 20/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director F. B. Weishaar & Son
(b) Address 1300 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 20 1947 Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 16/47 at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/3 19 47 to 1/16 19 47, and that I last saw him alive on 1/15 19 47.

Immediate cause of death Coronary Thrombosis

Due to Chronic Myocarditis

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature A. Hernsheim

Address Frederick, Md. Date signed 1/18/47 M. D.

X

G47674

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 47D

G47674 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct Age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 dys
(e) Length of stay in Baltimore (yrs., mos., or days) 9 4 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State N. J. (b) County
(c) City or town Newark (If outside city or town limits, write RURAL and give town)
(d) Street No. 172 Roseville Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest B Riley

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 090-09-8666

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bessie Riley
6 (c) If alive, give age? years

7. Birth date of deceased (mo., day, yr.) 9-25-89

8. AGE: Years 57 | Months 4 3 | Days 24 23 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Passenger Agent

11. Industry or business

FATHER 12. Name Reuben H. Riley M.D.
13. Birthplace Md

MOTHER 14. Maiden Name Laura B. Simmons
15. Birthplace Md

16 (a) Informant Richards
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 20 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address McCulloh & Orchard Sts

19 JAN 20 1947 (b) Registrar Huntington Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18 1947 at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14 1947 to Jan 18 1947 and that I last saw him alive on Jan 18 1947

Immediate cause of death: Empyema, rt — Duration: 1 mo
Due to: Carcinoma of Rt Lung — 6 mos
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard C. Coan
Address Johns Hopkins Hosp. Date signed 1/20/47

VS 150

G47675

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

G47675 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3332 St Ambrose Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lucie L. Frampton

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-20-8182

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced: |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Joseph M. Frampton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 4, 1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 0 | 13 | hr. min. |

9. Birthplace Talbott Co. Maryland
(Town, county, and state)
10. Usual Occupation Saleslady.
11. Industry or business Shoe Co.

FATHER
12. Name William Madison Kirkman
13. Birthplace Maryland.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Maryland

16 (a) Informant Mr. Joseph M. Frampton
(b) Address 3332 St. Ambrose Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-47 (month) (day) (year)
(c) Cemetery or crematory Spring Hill Cem.
Location Easton Maryland.

18 (a) Funeral director Lazzaro Bros.
(b) Address 5005 Pk Ave Balto

19 (Date received by Registrar) JAN 20 1947 — Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/17/47 19 at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/25 1946 to 1/17 1947 and that I last saw h— alive on 1/17 1947.

| Immediate cause of death | Duration |
|---|---|
| Subcarcinoma Mammae | |
| Due to | |
| Due to | |
| Other Conditions Pulmonary Infiltration | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Roder M.D.
Address Sinai Hosp Balto Md Date signed 1/17/47 M. D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D 47676 G47676 G47676 G47676

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 198

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 954 Forrest St.
(c) Hospital or institution: Maryland Penitentiary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs. 7 mos. 27 ds.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1527-b Lombard (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Lee Carmen

3 (b) If veteran, name war None
3 (c) Social Security Account No. 77

4. Sex Male | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21, 1923

8. AGE: Years 23 | Months 0 | Days 27 | If less than one day hr. min.

9. Birthplace Greenville, N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Charley D. Lee
13. Birthplace North Carolina

MOTHER 14. Maiden Name Idelly Carmen
15. Birthplace North Carolina

16 (a) Informant
(b) Address

17 (a) Burial - (Burial, cremation, or removal) (b) Date thereof Jan 21 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director A. Halsted
(b) Address 948 Druid Hill Ave

JAN 20 1947 (Date rec'd by registrar) (b) Williams Md. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 17 1947, at 12:40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 6 1945 to Jan. 17 1947 and that I last saw him alive on Jan. 17 1947

| Immediate cause of death | Duration |
|---|---|
| Dislocation of 5th cervical vertebra | |
| Due to Execution by hanging | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John F. Aubrey
Address Md. Penitentiary Date signed 1-27-47

G47677 BC# G66255 G47677

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓182a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1337 Brunt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Harry J. Queen

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Child |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/13/46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 1 | 7 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business Child

FATHER
12. Name James Queen
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Thomas
15. Birthplace Frederick, Md.

16 (a) Informant Cora Waters
(b) Address 1337 Brunt St.

17 (a) Burial (b) Date thereof Jan 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill, Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (b) Huntington Williams

JAN 20 1947

VS 111

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 1-17-1947, at 10 30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Suffocation

Due to Partial obstruction

Other Conditions Petechial Hemorrhages.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/17/47 at 4 30 A M 17/2
(b) Where did injury occur? 1337 Brunt st
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Suffocated in bed.

23. Signature Howard J. Owens M.D.
Medical Examiner.
Date signed 1-17-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47678

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48B

Registered No. G47678

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2818 Harvard ave
(c) Hospital or institution:
no
(d) Length of stay in hospital or inst. (yrs., mos., or days) no
(e) Length of stay in Baltimore (yrs., mos., or days) 4e

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2818 Harvard ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Amelia Louise John

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| ✓ | ✓ |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | white | Single |

6 (b) Name of husband or wife March 10 - 1885
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/10/1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 10 | 8 6 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation at Home
11. Industry or business

**FATHER**
12. Name Ernest E. John
13. Birthplace Baltimore Md

**MOTHER**
14. Maiden Name Do not know
15. Birthplace Baltimore Md

16 (a) Informant Mrs Estelle Knapp (Sister)
(b) Address 2818 Harvard av

17 (a) Burial (b) Date thereof Jan 20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md
18 (a) Funeral director Walter Funeral Home
(b) Address 2008 Orleans St

19 JAN 20 1947 Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 16 1947, at 4 15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 1946 to June 16 1947 and that I last saw her alive on June 16 1947.

| Immediate cause of death | Duration |
|---|---|
| Bronchus Pneumonia | 2 d. |
| Due to Carcinoma of Uterus | 6 mo |
| Due to Metastasis | |
| Lungs liver etc | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation Dec 16
Major findings of operation: Ca of Uterus
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S Sa Stevens M. D.
Address 2818 Harford Md Date signed 1-18-47

X

RAUKKO

G17679

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH ✓ 937

Registered No. G17679

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address CALVERT + 33rd
(c) Hospital or institution:
Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) —

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Sparrows Point
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rt 10, Box 168
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Finland

3 (a) FULL NAME JOHN W. RAUKKO

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Emma Ranta Raukko

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-11-96

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 10 | 7 | hr. min. |

9. Birthplace FINLAND (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name JOHANNES RAUKKO
13. Birthplace FINLAND

MOTHER
14. Maiden Name ?
15. Birthplace —

16 (a) Informant EMMA RANTA RAUKKO
(b) Address Rt 10, Box 168, SPARROWS POINT, MD

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 21, 1947 (month) (day) (year)

(c) Cemetery or crematory Oaklawn
Location Eastern Avenue

18 (a) Funeral director Roland L. Fisher
(b) Address 2112 Dundalk Ave.

JAN 20 1947 (b) Huntington Williams, M.D.
(Date received by Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-14 1947; at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-14 1947 to 1-14 1947 and that I last saw h[illegible] alive on 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral hemorrhage | 2 days |
| Due to Hypertension | ? |
| Due to Chronic vascular disease | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 1-14-47

VS 150

Hospital X

G17680

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G17680 Registered No. 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1005 N. Monroe St.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 N. Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** FRANCIS H. TOWNSEND

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary S. Townsend (nee Holmes)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1872

8. AGE: Years 74 | Months 0 11 | Days 26 2[illegible] | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business National Capital Press

FATHER
12. Name Francis H. Townsend
13. Birthplace Cambridge, Md.

MOTHER
14. Maiden Name Eliza Clendenin
15. Birthplace -

16 (a) Informant J. W. Townsend
(b) Address Chevy Chase Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-21-47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) (b) Registrar

JAN 20 1947 [illegible] Md.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 17 1947 at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1947 to Jan 17 1947, and that I last saw h[illegible] alive on Jan 16 1947.

| Immediate cause of death | Duration |
|---|---|
| Right Hemiplegia. | |
| Due to Hypertension. | |
| Due to Chr. nephritis. | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George E. Shannon M.D.
M. D.
Address 820 medical Arts Bldg. Date signed 1/18/47

X

G47681

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 638

G47681

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4630 Clsewde Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4630 Elsewde Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mattie Lee Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F. | W. | Divorce |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 13, 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 10 | 4 | min. |

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business?

FATHER
12. Name Bucker
13. Birthplace Effingham

MOTHER
14. Maiden Name Ellen
15. Birthplace Effingham

16 (a) Informant Mrs Blone
(b) Address 4630 Elsewde Ave

17 (a) Burial (b) Date thereof 1/20/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lakewood
Location Taylor Ave

18 (a) Funeral director Patel Heyman
(b) Address 6067 Hay St

19 (a) JAN 20 1947 Harry [illegible]
(Date received) (Registrar)

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Jan 17 1947 at M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan. 1943 to 1-17 1947 and that I last saw her alive on 1-16 1947.

| Immediate cause of death | Duration |
|---|---|
| Myocardial Failure | 1 week |
| Due to Toxic Adenoma of Thyroid | 3 years |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23. Signature** E. W. Peake M. D.

Address 4508 Harford Rd Date signed 1-19-47

X

MALIKER

G47682

G47682

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1843a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2429 E. Monument St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max (Harris) Maliker

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | | | hr. min. |

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business Russia

FATHER 12. Name unknown

FATHER 13. Birthplace Russia

MOTHER 14. Maiden Name unknown

MOTHER 15. Birthplace Russia

16 (a) Informant Ida Maliker

(b) Address 2429 E Monument St

17 (a) Burial (b) Date thereof 1-20-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Sons

(b) Address 1429 E Baltimore St

19 (a) JAN 20 1947 (b) Huntington Williams
(Date rec'd by registrar) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-19 1947 at 8:22 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19 1947 to 1-19 1947 and that I last saw h[illegible] alive on 1-19 1947

Immediate cause of death Cerebral Vascular Accident — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathan B. Hyman M. D.

Address Sinai Hospital Date signed 1-19-47

G47683

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1318

G47683 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1325 W. SARATOGA St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 W Saratoga Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Ethel G. Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Colored | Married |

6 (b) Name of husband or wife Anthony Carter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24 1893

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | 8 | 24 | hr. min. |

9. Birthplace Anne Arundel County Md (Town, county, and state)
10. Usual Occupation Arundel Ice Cream Co
11. Industry or business

FATHER
12. Name Alberta M. Byrd
13. Birthplace Va

MOTHER
14. Maiden Name Annie Freeland
15. Birthplace Calvert County Md

16 (a) Informant Anthony Carter
(b) Address 1325 W Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 21 1947 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Cemetery
Location Baltimore City

18 (a) Funeral director Joseph A. Sisley
(b) Address 1411 West Baltimore Street

19 (c) JAN 20 1947 [illegible]

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 17 1947, at 12:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1946 to Jan 17 1947 and that I last saw h-- alive on Jan 16 1947

| Immediate cause of death | Duration |
|---|---|
| Cardiac Fibrillation | |
| with auricular involvement | 3 |
| Due to Pulmonary Edema | 3 |
| Due to Chronic Nephritis | 7 |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Vernon L French MD
Address 73-79 Arundel Ave Date signed 1/17/47 (M. D.)

G47681

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 164a

G47684 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 436 N. Payson st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 26yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 436 N. Payson st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Oakley M. Watkins

3 (b) If veteran, name war: World War-1.

3 (c) Social Security Account No. 216-01-3683

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Estelle E. Watkins.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3-1896.

8. AGE: Years 50 | Months 11 | Days 14 | If less than one day hr. min.

9. Birthplace Howard Co. Md.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Calvin Watkins
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Mary Brandenburg.
15. Birthplace Howard Co. Md.

16 (a) Informant Mrs. Estelle E. Watkins.
(b) Address 436 N. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 20-47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery.
Location

18 (a) Funeral director Charles J. Schwab.
(b) Address 3512 Frederick Ave.

19 (a) [illegible] (b) [illegible]

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-17 19 47, at 1 P M

21. I certify that I took charge of the remains described above, held an Insp. Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Lie death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH asphyxiation

Due to Hanging

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/17/47 at 1 P. M.
(b) Where did injury occur? 436 N. Payson st.
(c) Did injury occur at home, on farm, industrial place, in public place? House While at work? No
(d) Means of injury Hanged self with rope

23. Signature Howard S. Mueller M.D.
Medical Examiner.
Date signed 1-17-47

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D47685

BALTIMORE CITY HEALTH DEPARTMENT

TN. 107510

# CERTIFICATE OF DEATH

13B

Registered No. G17685

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 109 N. Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Frank Christopher

3 (b) If veteran, name war

3 (c) Social Security Account No. 230-01-1738

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Seperated |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18th 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 0 | 1 | hr. min. |

9. Birthplace Mass.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Micheal Christopher
13. Birthplace Mass.

MOTHER
14. Maiden Name Catherine
15. Birthplace Mass.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 21-1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore City

18 (a) Funeral director H. B. M. Walter
(b) Address Platt & Stuckert Sts

19 (a) (Date rec'd by registrar) (b) Registrar

V S 150

JAN 20 1947

**MEDICAL CERTIFICATION**

445

20. DATE OF DEATH Jan. 19th 1947, at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 11th 1947, to Jan. 19 1947, and that I last saw him alive on Jan. 19 1947.

Immediate cause of death Pulmonary tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Douglas Waldron M. D.

Address BCH Date signed 1-19-47

X

BG# BALTIMORE CITY HEALTH DEPARTMENT

G17686 G6686 CERTIFICATE OF DEATH 159 Registered No. G17686

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Baltimore 25 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3412 Charles Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME NANCY LOUISE DEZAIFFE

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6, 1947

8. AGE: Years 0 | Months 0 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation baby
11. Industry or business

FATHER 12. Name Gilbert R. DeZaiffe
13. Birthplace Pennsylvania
MOTHER 14. Maiden Name Erma Louise McLeod
15. Birthplace Florida

16 (a) Informant Father
(b) Address 3412 Charles Court Balto 25

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-20-46 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Arlington Md

18 (a) Funeral director Stewart Memorial Co.
(b) Address 108 Monument

19 (a) (Date rec'd by Registrar) (b) Registrar

JAN 20 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-18 1947, at 11:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1947, to Jan 18 1947, and that I last saw her alive on Jan 18 1947.

Immediate cause of death: Acute Nutritional Disturbance — Duration 3½ days
Due to: Pneumococcic peritonitis — Duration ?
Due to:
Other Conditions: Prematurity
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Pneumoc. Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Katherine Sprunt M. D.
Address Union Memorial Hospital Date signed 1-19-47

X

G47687 Died Infancy (G-6826)

TN. 107609

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

Registered No. G47687

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly!

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals 26 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 505 Tolna St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy Bittner ( Victoria

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14th 1947

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Bittner
13. Birthplace Maryland

MOTHER
14. Maiden Name Victoria ?
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records)

17 (a) Cremation (b) Date thereof 1-17-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Crematory
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

19 JAN 20 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION** P.M.

20. DATE OF DEATH Jan. 15/ 1947 19 , at 10.45 M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 14/ 1947, to Jan. 15 1947, and that I last saw h. im alive on Jan. 15/ 1947

Immediate cause of death: Cerebral Anoxemia — Duration: 1 day

Due to:

Due to:

Other Conditions: Prematurity — 1 day

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julian L. Griffin M. D.
Address Balt. City Hosp. Date signed Jan 16 1947

V S 150

TN. G17688 105367

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G17688

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3- & 1
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 N. Wolfe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** James Frank

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-16-5635

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9th 1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 11 | 10 | hr. min. |

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Chauffeur Baker
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Ferdinand
13. Birthplace ?

MOTHER
14. Maiden Name Mary ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records )

17 (a) Burial (b) Date thereof 1/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st

19 (a) (Date rec'd by registrar) (b) Registrar

V S 150 JAN 20 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 19th 1947 19 , at 2.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 18th 1947, to Jan. 19 1947, and that I last saw h im alive on Jan. 19 1947

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Pulmonary Tuberculosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Pulmonary Tuberculosis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Doyle Wallace M. D.
Address BCH Date signed 1-21-47

Huntington Williams

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G17689

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 B

G17689 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Olivia Caroline
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 917 St. Paul Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Rovenia M. Timmons

3 (b) If veteran, name war —
3 (c) Social Security Account No. None

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | W |

6 (b) Name of husband or wife Jake
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 12 1864

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | 3 | 6 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Wingate
13. Birthplace Md

MOTHER
14. Maiden Name Lona Fuller
15. Birthplace Md

16 (a) Informant Rita Lee
(b) Address 917 St Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Tilton & Son
(b) Address 1217 St Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 JAN 20 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18, 1947, at 5:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/9 1947, to 1/18 1947, and that I last saw h.e. alive on 1/18 1947.

Immediate cause of death Cardia - Respiratory Syndrome
Due to Carcinoma of Stomach
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard H. Young M.D.
Address St Josephs Hospital Date signed 1/18/47

X

G47690

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 52B

Registered No. G47690

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 wk.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 wk.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4214 W Pratt ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Schweinberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Jane Schweinberg

6 (c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.) 7-24-70.

8. AGE: Years 76 | Months 5 | Days 22 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Steamfitter

11. Industry or business

FATHER 12. Name William Schweinberg

13. Birthplace Germany

MOTHER 14. Maiden Name Susie Poldeman

15. Birthplace Germany

16 (a) Informant Charles Schweinberg

(b) Address 4214 W Pratt ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 20, 1947 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore

18 (a) Funeral director Frederick A. Cole

(b) Address 1300 E. Lombard St.

19 (Signature of registrar) JAN 20 1947 (Date received by registrar) Registrar Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16 1947 at 6:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 9 1947 to Jan. 16 1947 and that I last saw h alive on Jan 16 1947.

Immediate cause of death: Pneumonia — Duration: 7

Due to Bilateral renal Block — 3 days

Due to Carcinoma of bladder — ?

Other Conditions Hypostasis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: 1-16-47

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Athel Woodson M. D.

Address Johns Hopkins Hosp. Date signed 1-16-47

G17691 BG# G67036

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1578

Registered No. G17691

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: Fayette & Eulaski Sts.
(c) Hospital or institution: Bon se Cour Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days): Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 1519 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country?: (Yes or No)
If yes, name country:

**3 (a) FULL NAME:** Durwood Pickelsimer

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 31, 1946.

8. AGE: Years | Months | Days: 18 | If less than one day: hr. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation:
11. Industry or business:

FATHER
12. Name: Durwood Pickelsimer
13. Birthplace: Lenoir City, Tenn.

MOTHER
14. Maiden Name: Hannah Doherty
15. Birthplace: Dumbarton, Scotland

16 (a) Informant: Durwood Pickelsimer
(b) Address: 1519 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1/21/47. (month) (day) (year)
(c) Cemetery or crematory: Western
Location: Baltimore

18 (a) Funeral director: Frederick A. Cole
(b) Address: 1200 W. Fayette St.

19 (a) JAN 20 1947 (Date received by registrar) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Jan 18 1947, at 3:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 18 1947 to Jan 18 1947 and that I last saw him alive on Jan 18 1947.

Immediate cause of death: Respiratory failure — Duration:
Due to: Atropine poisoning
Due to:
Other Conditions: Double pyloric stenosis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?: (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?: (Specify type of place)
(e) Means of injury:

23. Signature: H. Williams Cole M. D.
Address: Bon Secours Hosp. Date signed: 1/20/47

VS 150

G47692

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V-309

G47692 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address M
(c) Hospital or institution: Mercy Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 49da
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 641 N. Calhoun St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Gladys Watkins

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | black | single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1902

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 44 | 3 | 22 | hr. min. |

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Thomas Watkins
13. Birthplace Virginia

MOTHER
14. Maiden Name Florence
15. Birthplace

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/21/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Chas. G. Kefauver
(b) Address 1303 Pennsylvania Ave

19 (a) (Signature) (b) (Registrar)

JAN 20 1947 Hattie Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-16 — 1947 at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h[illegible] alive on 1-16-47 19

| Immediate cause of death | Duration |
|---|---|
| respiratory failure | |
| Due to cirrhosis of liver | 49 days |
| Due to | |
| Other Conditions tertiary syphilis | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy cirrhosis of liver

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature [illegible] J. Gutach M. D.
Address Mercy Hosp. Date signed 1-16-47

X

G47693 Russell

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1318

Registered No. G47693

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3018 Etting St
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2318 Etting St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Robert Edward Russell

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 217-01-3881

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | W |

6 (b) Name of husband or wife: Edna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/24/1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 10 | 23 | hr. min. |

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Manuel Russell

FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Eliza Smallwood

MOTHER 15. Birthplace Md

16 (a) Informant Dorothy Cothorn

(b) Address 2318 Etting St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/20/44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md.

18 (a) Funeral director Geo. A. Kelson

(b) Address 1303 Greenleaf St

19 (a) JAN 20 1944 (Date received by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/17/44 19 , at 2 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11 19 44 to 1/17 19 44, and that I last saw h alive on 1/17 19 44

| Immediate cause of death | Duration |
|---|---|
| Ch. Nephritis | |
| Due to Uremia | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm R Leith M. D.

Address Date signed 1/18/44

VS 189

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

TN. G47694 107285

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 74a

Registered No. G47694

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1300 Hauber St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dewis Clifton anthony

3 (b) If veteran, name war: War # 1

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ethel Mae

6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) June 6th 1912

8. AGE: Years 34 | Months 5 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER
12. Name Charles Anthony
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Pearl Pierson
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/46 (month) (day) (year)
(c) Cemetery or crematory Centerville Cem.
Location Centerville, Maryland

18 (a) Funeral director John F. Denny, Inc.
(b) Address 715 Light St.

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

JAN 20 1947

Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 18th/1947 19____, at 8.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 3rd/ 1947, to Jan. 18th 1947, and that I last saw h im alive on Jan. 18th 1947.

| Immediate cause of death | Duration |
|---|---|
| Hemorrhage from ruptured spleen | |
| Due to Acute splenic tumor | |
| Due to Myelogenous Leukemia (?) | over |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Ruptured enlarged spleen

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Dwight Waldron M. D.

Address B C H Date signed 1-13-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G17695

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

83a

G17695
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 420 Arnold ave (If rural give location)
(e) Citizen of foreign country? Wasn't (Yes or No) If yes, name country

**3 (a) FULL NAME** Ernest FLEET JEETER

3 (b) If veteran, name war: WORLD WAR I
3 (c) Social Security Account No.:

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | SINGLE |

6 (b) Name of husband or wife [redacted]
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | | | hr. min. |

9. Birthplace MASONVILLE, MD. (Town, county, and state)
10. Usual Occupation BRAKEMAN
11. Industry or business RAILROAD B+O

FATHER
12. Name REUBEN JEETER
13. Birthplace VIRGINIA

MOTHER
14. Maiden Name NANNIE P. JORDAN
15. Birthplace VIRGINIA

16 (a) Informant EDWARD L. JEETER
(b) Address 1200 CHESAPEAKE AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1 21 47 (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL
Location ANNAPOLIS BLVD.

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST.

19 (a) [illegible] (b) JAN 20 1947 Registrar

VS 151

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 1-17- 1947, at 5 50a M

**21.** I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Acute cerebral edema

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 1/17/47

X

G47696

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 186a

G47696 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2855 Lake Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Zlawnicka

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Mary Zlawnicka
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1863

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 82 | 11 | 29 | hr. min. |

9. Birthplace Bohemia (Town, county, and state)
10. Usual Occupation Boot maker
11. Industry or business

FATHER
12. Name Charles Zlawnicka
13. Birthplace Bohemia

MOTHER
14. Maiden Name Emma Barta
15. Birthplace Bohemia

16 (a) Informant Mamie Zlawnicka
(b) Address 2855 Lake Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 21/47 (month) (day) (year)
(c) Cemetery or crematory Oakfield
Location Balto Md

18 (a) Funeral director Frank Borchardt
(b) Address 2901 Edmondson Ave

19 (a) JAN 20 1947 (Date rec'd by registrar) Washington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/18 1947 at 1:13 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/17 1947 to 1/18 1947 and that I last saw h[illegible] alive on 1/18 1947.

Immediate cause of death ~~Hemiplegia~~ Acute Alcoholism C.V.D. — Duration 2 days

Due to ~~Fall down steps~~

Due to

Other Conditions Fracture inj. to head due to fall down steps
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 8/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 1-17-47 at 6:00 P.M.
(c) Where did injury occur? Balto City (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell down steps, inside

23. Signature Wm. A. Langley M. D.
Address St Agnes Hosp. Date signed 1-19-47

VS 150

For Dr. J.R. Oland, by Howard J. Tamburro, M.D. X

G17697

BALTIMORE CITY HEALTH DEPARTMENT

TN. 106508 **CERTIFICATE OF DEATH** 1/24 B

Registered No. G17697

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 18 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 136 N. Castle St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Ada Keller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30th 1892

8. AGE: Years 54 | Months 7 | Days 18 | If less than one day ____hr. ____min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Salmon
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Anna
15. Birthplace: Maryland

16 (a) Informant: Baltimore City Hospitals
(b) Address: 4940 Eastern Ave ( Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 22-47 (month) (day) (year)
(c) Cemetery or crematory Bethel
Location E. North, am

18 (a) Funeral director John E. Ingram
(b) 1847 300 E. Eager St.

19 (a) (Date rec'd by registrar) (b) Washington Williams M.D.

V S 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 18th 1947 19___, at 9.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30th 1946 to Jan. 18 1947, and that I last saw her alive on Jan. 18th 1947

Immediate cause of death: Cirrhosis of liver — Duration: 5 mos (?)

Due to:

Other Conditions: Fibrinous pleurisy left. Recent pulmonary atelectasis. Ascites. Esophageal varices. (Include pregnancy within 3 months of death)

Date of operation: 0

Major findings of operation:

of autopsy: as above

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: R. H. Zeibels M. D.

Address: Baltimore City Hosp. Date signed 1/19/47

G47698

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 95c

G47698 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 401 E. 25th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 563 E 38th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Marie L. Hartman

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 7th 1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 2 | 10 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business at Home

FATHER
12. Name John C. Hartman
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Margaret Beil
15. Birthplace Baltimore Md

16 (a) Informant John C. Hartman
(b) Address 601 E 41st St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 21/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director John C. Moran
(b) Address 3000 E Baltimore St

19 (a) Filed JAN 20 1947 (b) Registrar Huntington Williams, M.D. Registrar

V S 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 17th 1947 at 9:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 17th. 47 Jan. 17th. 47. 19 19 and that I last saw her alive on Jan. 17th. 47. 19 19.

Immediate cause of death: Pulmonary Oedema — Duration: about 30 min.
Due to: Acute Cardiac Dilitation
Due to:
Other Conditions: Hypertension — about 7 yr
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jas W. Hartzog M.D.
Address 401 E. 25th. St. Date signed 1/18/47.

For Dr J.R. Davis, by Howard J. Medicis, M.D.

G17699

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G17699

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5135 FREDERICK AVE
(c) Hospital or institution: 25

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5135 FREDERICK AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** WILLIAM D. MARIS

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| MALE | WHITE | WIDOWED |

6 (b) Name of husband or wife MARY A
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 25, 1849

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 97 | 2 | 23 24 | hr. min. |

9. Birthplace BALTIMORE, MARYLAND
(Town, county, and state)
10. Usual Occupation BRAKEMAN RETIRED
11. Industry or business B. & O. R.R.

FATHER
12. Name LOUIS MARIS
13. Birthplace PENN

MOTHER
14. Maiden Name FANNIE DGLASHELL
15. Birthplace FRANCE

16 (a) Informant HOWARD G. BRAECKLEIN.
(b) Address 5135 FREDERICK AVE

17 (a) BURIAL (b) Date thereof 1-21-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Frederick Ave.

18 (a) Funeral director Ambure, Inc.
(b) Address 414 N. Frankletown Rd.

JAN 20 1947
(Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan. 18th 1947 at 7:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 11 1947 to Jan 18 1947, and that I last saw h.. alive on Jan 18th 1947.

| Immediate cause of death | Duration |
|---|---|
| Myocarditis | 2 yrs |
| Due to | |
| Due to Essential Arteriosclerosis | 6 yrs. |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Howard G. Braecklein.
Address 517 Aisquith St Date signed 1/19/47

V S 150

X

G47709

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 92c

G47709 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U.S.Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hr. 55 minutes
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 830 Tyson Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Harris, George Warfield

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| WW1 | - - - - |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | Col. | single |

6 (b) Name of husband or wife - - - -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | 7 | 19 | hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Veteran

FATHER
12. Name George W. Harris
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Annie Kenneth
15. Birthplace Kent Co., Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof Jan. 22, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (b)
(Date rec'd by registrar) (Registrar)

JAN 20 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 17 1947, at 9:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 17 1947 to Jan. 17 1947 and that I last saw him alive on Jan. 17 1947.

| | Duration |
|---|---|
| Immediate cause of death aortitis with aortic insufficiency | |
| Due to Cardiac Hypertrophy with failure and | |
| Due to Pulmonary Infarction | Unknown |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy: As Above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Asst Surg USPHS
Address U.S. Marine Hospital, Balto. Md. Date signed 1/18/47

X

G1770i

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G1770i

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5736 Ridgedale Road.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5736 Ridgedale Road.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** PAULINE OPPENHEIMER.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single. |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1873.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 6 | 4 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None.
11. Industry or business

**FATHER**
12. Name Abraham Oppenheimer,
13. Birthplace Germany.

**MOTHER**
14. Maiden Name Babette Einstein,
15. Birthplace Germany.

16 (a) Informant Mrs. Harry Goldsmith,
(b) Address 5736 Ridgedale Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1.21.47. (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom
Location Balto. Md.

18 (a) Funeral director Harris, Levy & Levy
(b) Address 1902 Eutaw Place Williams, Md.

19 (a) JAN 20 1947 (Date received by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 19th. 1947 at A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1941, to Jan. 19 1947, and that I last saw h[illegible] alive on Jan 19 1947

Immediate cause of death — Duration

Acute Coronary Thrombosis — 20 min

Due to chr. coronary artery Disease

Due to Hypertension Cardiac Insuff

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bernard Cohen M. D.
Address Marlborough Apts. Date signed

VS 150

G47703

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

131a

Registered No. G47703

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 655 George st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 655 George St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mr Charles Thompson
3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | W |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | | | hr. min. |

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER 12. Name Eleven Thompson
13. Birthplace Eastern Md.

MOTHER 14. Maiden Name Martha Phelps
15. Birthplace Maryland

16 (a) Informant Miss Jewett Thompson
(b) Address 512 N Carlton [illegible]

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-21-47 (month, day, year)
(c) Cemetery or crematory Laurell Cemetery
Location Eloy D Wilson

18 (a) Funeral director
(b) Address 1000 Bradley Ave

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 1947, at 5 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 25 1946 to Jan 17 1947, and that I last saw h[illegible] alive on Jan 17 1947.

Immediate cause of death Chronic Nephritis — Duration: Several years
Due to
Due to
Other Conditions None
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. L. Peltz M. D.
Address 817 Hamilton Ave Date signed Jan 21 47

JAN 20 1947 Hamilton for Williams, Md

Md 7388 X

G17703

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G17703

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles H. Streeter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 20, 1900

8. AGE: Years 46 | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and State)

10. Usual Occupation Coal & Wood Dealer

11. Industry or business

FATHER
12. Name Haywood Streeter
13. Birthplace N.C.

MOTHER
14. Maiden Name Nealy Roscoe
15. Birthplace N.C.

16 (a) Informant Arthur Streeter
(b) Address Leyden N.C. Route 1 Box 116

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Rockymount N.C.
Location N.C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan. 17, 1947, at 8 50 A.M.

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Uhrich M.D.
Medical Examiner.
Date signed 1/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47704

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 30E

G47704 Registered No. 1

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5

(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 min
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1124 E Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Bessie Chance

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | S |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 40 | | | hr. min. |

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name not None
13. Birthplace "

MOTHER
14. Maiden Name not None
15. Birthplace "

16 (a) Informant Alfred Johnson (Friend)
(b) Address 1124 E Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 23rd 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Baltimore Md

18 (a) Funeral director Elroy A Wilson
(b) Address 1000 Pratt St

19 (a) JAN 20 1947 (Date received by registrar) Baltimore, Md

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/18 1947, at 8:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h[illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cardiac C.V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If fatal cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature E. P. Sulzinski M.D.
Medical Examiner.
Date signed 1/20/47

VS 151

G47705

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G47705 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 807 S. Clinton Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4323 Falls Road (If Rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Emily Boat

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Joseph C. Boat
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23-1863

8. AGE: Years 83 | Months 7 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name William L. Gardner
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Kirby
15. Birthplace Maryland

16 (a) Informant Mrs. Blanche Brown
(b) Address 4323 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 22-1947 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore Co., Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date rec'd by Registrar) (b) Registered No.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 19 1947, at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 16 1946 to Jan 19 1947, and that I last saw h alive on Jan 19 1947.

| | Duration |
|---|---|
| Immediate cause of death Cardiovascular Renal Disease | 9-16-46 |
| Chronic myocarditis | Jan 5/47 |
| Due to Myocardial Failure | 1-19/47 |
| Acute Coronary Occlusion | |
| Due to | |
| Other Conditions None | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide?
(b) Date of occurrence None at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. A. Schimmel M. D.
Address 842 S. Ext Ave Date signed 1-19-47

Huntington Hillsboro, Md.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47706

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

G47706 ✓ Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2437 Washington Boulevard
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2437 Washington Boulevard (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Cecelia Evans

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edmond E. Evans.
6 (c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Aug. 14, 1884

8. AGE: Years: 62 | Months: 5 | Days: 4 5 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Thomas Hasleys
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Fontz
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Edmond E. Evans
(b) Address: 2437 Washington Boulevard

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan 21 1947 (month) (day) (year)
(c) Cemetery or crematory: Loudon Pk
Location: Balto & Edmond Evans

18 (a) Funeral director: A. Howard Evans
(b) Address: 1400 S. Charles Street

19 (a) Date rec'd by Registrar: [illegible] (b) Registrar: [illegible]

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH: January 19, 1947 at 1:PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/8 1943 to 1/19 1947 and that I last saw h 9r alive on 1/18 1947

| | Duration |
|---|---|
| Immediate cause of death: Cardiac Insufficiency | 3 mos. |
| Due to: Arterio-Sclerotic Cardio-Vascular - Renal | 6 yrs. |
| Due to: Disease | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Lange A Kumpf M. D.
Address: 3030 Edmondson Ave Date signed: 1/20/47

X

G47707

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

Registered No. G47707

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGINS RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lexington St
(c) Hospital or institution: Home of Our Lady of Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec 13th 46 to Jan 19th 47
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 845 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Clara D. Hemingway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5th 1870

8. AGE: Years 76 | Months 5 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation house work

11. Industry or business at home

FATHER
12. Name John Andreos
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Lottie Richards
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Gertrude M Selfman
(b) Address 845 Washington Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 22nd 47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Greenmount Ave + Oliver St.

18 (a) Funeral director John J. Gorman & Son
(b) Address 901-03 Hollins St

19 (a) (Date rec'd by reg.) (b) Registrar

VS JAN 20 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 19th 1947, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 14 1947, to Jan. 19 1947, and that I last saw h[illegible] alive on Jan. 14 1947.

| Immediate cause of death | Duration |
|---|---|
| Hypostatic pneumonia | 7 |
| Due to Complicated Arteriosclerosis | 7 |
| Due to [illegible] | |
| Other Conditions Broken Pelvis - 1933 & 1944 Senile Dementia | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Linden M. D.
Address 14 E. Monument Date signed 1/20/47

X

G17708

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

Registered No. G17708

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 604 Stamford Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Stamford Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Harrison Wm Arnold

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Alice B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 7 | 16 | hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business

FATHER
12. Name Franklin Arnold
13. Birthplace Md. Md.

MOTHER
14. Maiden Name Minnie West
15. Birthplace West Va

16 (a) Informant Mrs Alice B. Arnold
(b) Address 604 Stamford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-19-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Wilkens Ave
18 (a) Funeral director Wm J. Cowan Son
(b) Address 40-42 Fulton St

19 (a) (Date received by Registrar) JAN 20 1947 (b) Washington Wilkinson, M.D. (Registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 19th 1947, at 9A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 18 1947 to Jan 19 1947 and that I last saw him alive on Jan 19 1947.

| Immediate cause of death | Duration |
|---|---|
| (a) Coronary Thrombosis | 1 hr |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter H. Crowther M. D.
Address 4209 Sinclair Ave Date signed 1/20/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47709

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G47709

107

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 929 Bevans St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 929 Bevans Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Charles Williams

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-8427

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | married |

6 (b) Name of husband or wife Gertrude

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) 1/15/1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 60 | - | 4 | hr. min. |

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mary Fields
(b) Address 929 Bevans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-22-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Balto City

18 (a) Funeral director Isaac L. Brown & Son
(b) Address 108 W. Montgomery St

19 (a) (Date received by Registrar) JAN 20 1947 (b) Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 1/19/47, 19..., at 8:00 A.M.

**21.** I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John Peters M.D.
Medical Examiner.
Date signed

VS 151

G47710

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 53

Registered No. G47710

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 511 North Port Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County North
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 N. Port St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** JOSEPH KOLBL

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife: Mary Kolbl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1864

| 8. AGE: Years | Months | Days | If less than one day: hr. | min. |
|---|---|---|---|---|
| 82 | 6 | 27 | | |

9. Birthplace Germany
10. Usual Occupation Retired, B & O. R. R. Co.
(Town, county, and state)
11. Industry or business

FATHER — 12. Name Unknown
13. Birthplace "

MOTHER — 14. Maiden Name "
15. Birthplace "

16 (a) Informant Irvin W. Crawford
(b) Address 511 North Port Street

17 (a) Burial (b) Date thereof 1/21/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison St.

19 (a) (Date rec'd by registrar) (b) Registrar

VR JAN 20 1947

Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 17 19 47 at 4:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to Jan. 17 1947 and that I last saw deceased alive on Jan 17 1947

Immediate cause of death Degenerative Heart Disease with terminal failure — Duration unknown to me

Due to Probable metastatic Carcinoma — unknown to me

Due to Primary Carcinoma on face — 1 year

Other Conditions Inguinal Hernia

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Francis J. Januszeski M. D.
Address 540 N. Linwood Ave Date signed 1-20-47

X

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

TN. G1107364 — Registered No. G17711

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days): 13 days
(e) Length of stay in Baltimore (yrs., mos., or days): Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: Maryland (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 2500 Francis St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Rose E. McDermott

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: 220-12-9279

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Donald M. McDermott

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 5th 1913

8. AGE: Years: 34 | Months: 0 | Days: 14 | If less than one day: hr. min.

9. Birthplace: Maryland (Balto.)
(Town, county, and state)

10. Usual Occupation: Clerk

11. Industry or business:

FATHER
12. Name: Howard E. Ewing
13. Birthplace: Maryland (Balto.)

MOTHER
14. Maiden Name: Florence M. Bryant
15. Birthplace: Maryland (Balto.)

16 (a) Informant: Baltimore City Hospitals
(b) Address: 4940 Eastern Ave ( Records )

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/47 (month) (day) (year)
(c) Cemetery or crematory: Western
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by Registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 19th 1947, at 1.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 6th 1947, to Jan. 19th 1947, and that I last saw him alive on Jan. 19th 1947.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Pulmonary Tuberculosis | |
| Due to | |
| Other Conditions Tuberculosis Cystitis | |

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: Pulmonary Tuberculosis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: W. Doyle Wallace, M. D.
Address: B C H Date signed: 1-19-47

V S 150

Huntington Williams, M.D.

G17712 ✓ G17712

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 736 N. Fulton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 736 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Haupt

3 (b) If veteran, name war: World I
3 (c) Social Security Account No.: no

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Sadie Haupt
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): April 9, 1883
8. AGE: Years 63 | Months 9 | Days 9 | If less than one day hr. min.
9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Painter (retired)
11. Industry or business

FATHER
12. Name: John Haupt
13. Birthplace: Germany

MOTHER
14. Maiden Name: Gertrude Hafer
15. Birthplace: Germany

16 (a) Informant: Mrs. Sadie Haupt
(b) Address: 736 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/21/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/18 1947, at 11:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Thrombosis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature G. F. Sulzbacher M.D.
Medical Examiner.
Date signed 1/18/47

X

G47713 — BALTIMORE CITY HEALTH DEPARTMENT — G47713 Registered No.

# CERTIFICATE OF DEATH 170C

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Halethorpe (If outside city or town limits, write RURAL and give town)
(d) Street No. 2919 Ohio Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Mollie Foesler

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John Wilhom (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1869

8. AGE: Years 77 | Months 11 | Days 27 28 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name Patrick Horn
13. Birthplace Ireland

MOTHER — 14. Maiden Name Margaret Hollen
15. Birthplace Ireland

16 (a) Informant Mrs. Margaret M. Hoen
(b) Address 2919 Ohio Ave. Balto 27 Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-23-47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director Williams Locke Lee.
(b) Address 1217 St. Paul St.

JAN 20 1947 (Date rec'd by registrar) [illegible] Williams [illegible]ar

VS 181

## MEDICAL CERTIFICATION 26

20. DATE OF DEATH January 18 1947, at 11 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull, Avulsion of brain tissue, Intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/18/47 M.
(b) Where did injury occur? 2900 Elk ohio Ave. Halethorpe
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by Auto. "Hit & Run" Driver

23. Signature Thomas J. Weedon M.D. Medical Examiner.
Date signed 1/20/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G17711

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

186a

G17714 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 9
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 710 E. 21st St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ROLAND BENSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widower |

6 (b) Name of husband or wife Marie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-14-1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | 6 | 4 16 | hr. min. |

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business Pa. Rr

FATHER
12. Name Harry L. Benson
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sarah McConday
15. Birthplace Balto. Md.

16 (a) Informant Edward L. Benson
(b) Address Lancaster, Penna.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 12 E. Saratoga St.

19 (a) JAN 20 1947 Date rec'd by registrar (b) Washington Williams, Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-18- 1947, at 11 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Atelectasis left lung.
Fractured left ribs.
~~Duo~~ Edema of brain.
Fat infiltration of liver.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-17-47 at ? P. 12/5 M.
(b) Where did injury occur? 3026 Maryland Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Private Residence While at work? No
(d) Means of injury Slipped and fell downstairs

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 1/20/47

VS 151

G47715

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a (Registered No.)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 31st & St Paul Sts
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 31st & St Paul Sts (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Mathias L Hartman

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Oscar Hartman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov 20 1895

8. AGE: Years: 51 | Months: 1 | Days: 29 | If less than one day: hr. min.

9. Birthplace: Louisville Ky (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER — 12. Name: John Tilghman
13. Birthplace: Ky

MOTHER — 14. Maiden Name: Sophia Euler
15. Birthplace: Ky

16 (a) Informant: Oscar Hartman
(b) Address: Hopkins Hosp

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/21/47 (month) (day) (year)
(c) Cemetery or crematory: Cove Hill
Location: Louisville Ky

18 (a) Funeral director: Tilton & Fox Inc
(b) Address: 1217 E Fond St

19 (a) 1947 Huntington Williams, M.D. (Date rec'd by registrar) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19 1947, at 2:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 1946 to Jan 18 1947, and that I last saw her alive on Jan 16 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebro vascular accident | 1 hour |
| Due to Chronic psychoneurosis | 16 year |
| Due to Secondary hypertension | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Franklin C. Leslie M. D.

Address 1101 St Paul Date signed 1/20/47

G47716 ✓ G47716

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 95c

Registered No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town.....
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5804 York Road.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

**3 (a) FULL NAME** Elizabeth Ann Creager

3 (b) If veteran, name war.....
3 (c) Social Security Account No.....

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | Single |

6 (b) Name of husband or wife S
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1923

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 23 | 4 | 9 | .....hr. .....min. |

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Clerk - typist
11. Industry or business Veterans Administration

FATHER
12. Name Edmund M. Creager
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Alberta Creager
15. Birthplace 5804 York Road

16 (a) Informant Mrs. Alberta Creager
(b) Address 5804 York Road

17 (a) Burial (b) Date thereof 1/23/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory [illegible] Lawn Park
Location [illegible], Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street
(c) JAN 20 1947 (d) [illegible]
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan. 20, 1947; at 12.20 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.....
Acute dilatation of heart with hypertrophy
Acute pulmonary edema
DUE TO Congestion of all viscera

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Howard J. Uhlendorf M.D.
Medical Examiner.
Date signed 1-20-47

VS 151

G17717 G17717

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 181

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½ days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Passionist Monastery Old Frederick Rd. Monastery Ave.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rev. Fabian Fortune, C.P.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1890

8. AGE: Years 56 | Months 8 | Days 5 6 | If less than one day hr. min.

9. Birthplace Brooklyn, N.Y.
(Town, county, and state)

10. Usual Occupation clergyman

11. Industry or business

FATHER
12. Name William John Fortune
13. Birthplace Brooklyn, N.Y.

MOTHER
14. Maiden Name Madasia Walsh
15. Birthplace Brooklyn N.Y.

16 (a) Informant Hospital Record
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1-21-47 (month) (day) (year)

(c) Cemetery or crematory
Location Mount Olivet N.J.

18 (a) Funeral director George A. Kelly
(b) Address Baltimore, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 19 1947, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 16 1947, to Jan. 19 1947, and that I last saw him alive on Jan. 19 1947.

Immediate cause of death Cardiac failure, — Duration 6 hours.

Due to Hypertensive cardiovascular disease & cerebral accident — 2-3 years

Due to —

Other Conditions Pneumonia, R lower lobe — 2 days.
Burns 1st 2nd 3rd degree, face + neck
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 20/7

(a) Accident, suicide, or homicide accident

(b) Date of occurrence Jan. 16, 1947 at 1 P.M.

(c) Where did injury occur? Baltimore, Md.
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Monastery While at work? no.
(Specify type of place)

(e) Means of injury Burned by oil lamp.

23. Signature Lawrence E. Cannon M. D.

Address St. Agnes Hosp. Date signed Jan. 19, 1947

JAN 20 1947 for S. J. R. Davis, by Howard J. Malloy, M. D. X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47718

BALTIMORE CITY HEALTH DEPARTMENT X ✓ Registered No. G47718

# CERTIFICATE OF DEATH 518

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
Us Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days
(e) Length of stay in Baltimore (yrs., mos., or days) 33 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Va. (b) County
(c) City or town Byrdton (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Crowther, Otis Montague

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Henrietta Abrams
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) April 29, 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 8 | 22 | hr. min. |

9. Birthplace Northumberland Co., Va. (Town, county, and state)
10. Usual Occupation Master
11. Industry or business Seafarer

FATHER
12. Name Wm. H. Crowther
13. Birthplace Northumberland Co. Va.

MOTHER
14. Maiden Name Alberta Sims
15. Birthplace Va.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1-20-47 (month) (day) (year)
(c) Cemetery or crematory
Location Elmarnock Va
18 (a) Funeral director Geo A Farley
(b) Address Fulton r Fayette
19 (a) (Date rec'd by registrar) (b) Registrar

JAN 20 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 20 1947, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 18 1946 to Jan. 20 1947, and that I last saw him alive on Jan. 20 1947.

| Immediate cause of death | Duration |
|---|---|
| Myocardial infarction | 2 hrs. |
| Due to | |
| Due to | |
| Other Conditions Carcinoma of prostate (Include pregnancy within 3 months of death) | 1½ yrs. |

Date of operation
Major findings of operation:
of autopsy: None done

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 1/20/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G17719

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G17719 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604- W. Redwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** JOHN H. SODERQUIST

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | 2 |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | | | hr. min. |

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name
13. Birthplace
MOTHER 14. Maiden Name
15. Birthplace
16 (a) Informant
(b) Address
17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo JAN 20 1947
18 (a) Funeral director Commissioner of Health
(b) Address
19 JAN 20 1947 (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 5, 1947, at 11 a. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic heart disease.
Edema of lungs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 1-6-47

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47720

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

✓ G47720 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital. 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2120 Mura St. (roomer)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** FRED LEDFORD

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | 7 |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | | | hr. min. |

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/1947 (month) (day) (year)

(c) Cemetery or crematory Baltimore National
Johns Hopkins Medical Schoo JAN 20 1947

18 (a) Funeral director Ellwood Undertaking Co. Commissioner of Health
(b) Address 3911 Liberty Hgts Ave.

19 JAN 20 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan. 7, 1947, at 2.15 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis
Generalized Arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Weldon M.D.
Medical Examiner.
Date signed 1-8-47

G 7721

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 77c

Registered No. G 7721

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Daa.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 221 N. High Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Myles Earl Dietrick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 55 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name

13. Birthplace

MOTHER: 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Loc[illegible] Johns Hopkins Medical Schoo JAN 20 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 JAN 20 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** January 7, 1947, at 5:40 A M

**21.** I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH acute alcoholism, acute congestive cardiac failure, acute pulmonary edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wisedell M.D.
Medical Examiner.
Date signed 1-8-47

X

47722 BC# G66953

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 161a

✓ G47722 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2120 Division St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2120 Division St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Vernon C. Bumbray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1/6/97

8. AGE: Years: 8 mo. 7 days | Months | Days: 4 | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo JAN 20 1947

18 (a) Funeral director Commissioner of Health
(b) Address

JAN 20 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 191

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 20 1947 at 10:30 AM

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Atelectasis pneumatorum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walker M.D. Medical Examiner.
Date signed 1-20-47

G47723

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 92D

Registered No. G47723

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dou
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 697 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Walter Duball

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 45 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical Schoo JAN 20 1947

18 (a) Funeral director Commissioner of Health

(b) Address

JAN 20 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** January 8, 1947, at 5 P. M.

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Rest death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage (right lateral ventricle), Spontaneous

Due to

Other Conditions Hypertrophy and acute dilatation of heart, chronic valvulitis, Coronary sclerosis, Emphysema of lungs

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

**23.** Signature Howard J. Andersen M.D. Medical Examiner.

Date signed 1-8-47

VS 191

G47721

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 B

Registered No. G47721

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3118 O'Donnell st (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

**3 (a) FULL NAME** Frank Santoni

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M. | W. | W. Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26. 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 7 | 24 | hr. min. |

9. Birthplace Italy (town, county, and state)
10. Usual Occupation Grocer
11. Industry or business

FATHER
12. Name Damian Santoni
13. Birthplace Italy

MOTHER
14. Maiden Name Rose Polinni
15. Birthplace Italy

16 (a) Informant Adolfo Santoni
(b) Address 3118 O'Donnell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 23-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Frank V. Pipitone
(b) Address 2818 E. Baltimore St.

19 JAN 20 1947 (Date received) Huntington Williams, M.D. Registrar

VS 130

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/19 1947, at 1 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27 1946 to 1/19 1947, and that I last saw him alive on 1/19 1947.

Immediate cause of death Resp. Failure — Duration

Due to Metastatic Carcinoma

Due to Carcinoma of the Stomach.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1/3/47

Major findings of operation: Metastatic Carcinoma

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. W. Egerton M.D.
Address Univ. Hosp. Date signed 1/19/47

G 17725

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 B

Registered No. G 17725

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3706 Delverne Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 88 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3706 Delverne Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anne Lynch Quigley

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | white | widowed |

6 (b) Name of husband or wife Daniel Quigley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1858

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 88 | 6 | 22 | hr. min. |

9. Birthplace Baltimore - Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Philip Lynch
13. Birthplace Ireland

MOTHER
14. Maiden Name Anne O'Connor
15. Birthplace Ireland

16 (a) Informant Mary E. Forestell
(b) Address 3706 Delverne Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 22 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md

18 (a) Funeral director Henry W Jenkins Sons Co
(b) Address McCulloh & Orchard Sts

19 JAN 21 1947 (b) Huntington Williams, M.D. Registrar
(Date filed by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 19th 1947, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15th 1946 to Jan 19th 1947. and that I last saw h alive on Jan 17th 1947.

| Immediate cause of death | Duration |
|---|---|
| Cancer of Stomach | 1 Mo |
| Due to | |
| Due to | |
| Other Conditions Senility | |

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Chalfant M.D.
Address 620 York Rd Date signed Jan 19th 1947

VS 150

G47726

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1310

G47726 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Grant & Redwood Sts.
(c) Hospital or institution: University Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4006 Hickory Ave.
(If rural give location).
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Louis E. Baker

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-8169

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Nellie B. Baker
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Feb 17, 1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 07 | 11 | 2 | hr. min. |

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business High School

FATHER
12. Name James Baker.
13. Birthplace Md

MOTHER
14. Maiden Name Lucy Reese
15. Birthplace Md.

16 (a) Informant Nellie B. Baker
(b) Address 4006 Hickory Ave.

17 (a) Burial (b) Date thereof Jan 23 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn.
Location Woodlawn Md.

18 (a) Funeral director Benjamin Donovan
(b) Address 2615-17 Chestnut Ave.

JAN 21 1947 Huntington Williams M.D.
(Registrar) (Date received by Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-19 1947 at 3:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-7 1947 to 1-19 1947, and that I last saw him alive on 1-19 1947.

| Immediate cause of death | Duration |
|---|---|
| Regurgitation ceased. | |
| Due to Uremia | |
| Due to Chronic nephritis | |
| Other Conditions Arteriosclerosis & hypertension congestive failure. (Including pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. L. Crowell M. D.
Address University Hosp. Date signed 1-19-47

VS 150

G47727

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G47727

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3520 Chesterfield Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3520 Chesterfield Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MINA E. SCHOFIELD

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 213-09-4645

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife: William Henry Schofield
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 9 | 0 | hr. min. |

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Hecht Bros. Dept. Store

FATHER
12. Name Unknown
13. Birthplace W

MOTHER
14. Maiden Name W
15. Birthplace

16 (a) Informant Mr. Harry R. Schofield, son
(b) Address 3520 Chesterfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 21 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 18, 1947, at 11:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to Jan 18 1947 and that I last saw h[illegible] alive on Jan 18 1947.

Immediate cause of death: Coronary Thrombosis. — Duration

Due to: Arteriosclerosis

Due to: cardio-vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. B. Stevens
Address 3400 Eutaw Ave. Date signed 1/25/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G17728

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

Registered No. G17728

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3819 Belair Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3819 Belair Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARY LANDGRAF

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: George Landgraf

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1884

8. AGE: Years 62 | Months 4 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Frank Wehr
13. Birthplace Md.

MOTHER
14. Maiden Name Dora Meyers
15. Birthplace Md.

16 (a) Informant Mr. George Landgraf
(b) Address 3819 Belair Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/21/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 JAN 21 1947 (b) Huntington Williams, M.D. Address

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18, 1947, at 10:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1947 to Jan 18 1947.
and that I last saw her alive on Jan 18 1947.

Immediate cause of death: Cerebral Hemorrhage (Apoplexy)
Due to: Hypertension
Due to:
Other Conditions: Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wayter A Anderson M. D.
Address 3001 Shannon Drive Date signed
Balto 13 Md. Jan 20-47

VS 150

G47729

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G47729

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2422 N Charles St D.O.A.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2422 N Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Harry Williams

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 8, 1880

8. AGE: Years: 66 | Months: 11 | Days: 10 | If less than one day: hr. min.

9. Birthplace: Cardiff, Md.
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden Name: "
15. Birthplace

16 (a) Informant: Mr. James P. Williams
(b) Address: 2422 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/21/47 (month) (day) (year)
(c) Cemetery or crematory: Old Methodist Ch. Cem.
Location: Hyattstown, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 JAN 21 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/18 1947, at 11 00 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to h.s death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic CVD disease

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. F. Gulbrinks M.D. Medical Examiner.
Date signed 1/21/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

647730

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

12B

Registered No. 647730

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2868 Mayfield Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2868 Mayfield Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John M. Hecker

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widower |

6 (b) Name of husband or wife Christena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 18 1901

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 45 | 1 | 29 | hr. min. |

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation Balto Water Dept

11. Industry or business

FATHER
12. Name Henry Hecker
13. Birthplace Md

MOTHER
14. Maiden Name Susie Wahl
15. Birthplace Md

16 (a) Informant Mrs Susie Hecker
(b) Address Lutherville P O Md

17 (a) Burial (b) Date thereof Jan 21 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mayfield
Location Balto Md

18 (a) Funeral director Wilmer L Shindel Home
(b) Address 2008 Orleans St

19 (a) JAN 21 1947 Registrar
(Date received)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 17, 1947, at 6 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1947 to Jan 17 1947, and that I last saw him alive on Jan 14 1947

| Immediate cause of death | Duration |
|---|---|
| Pneumonia, Hypostatic | 3 days |
| Pulmonary Hemorrhage | 2 days |
| Due to Pulmonary Tuberculosis | unknown |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Homer L. Wardley Jr M. D.
Address 2900 Alameda Blvd Date signed Jan 16, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 929

Registered No. 31731

31731

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3038 Kenyon Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3038 Kenyon Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Rose (KATHERINE ROSE)

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1874

8. AGE: Years 72 | Months 1 | Days 13 12 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation schoolteacher

11. Industry or business Baltimore, retired

FATHER
12. Name Charles H. Rose
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Ammer
15. Birthplace Germany

16 (a) Informant Mrs. Arthur Reinheimer
(b) Address 8 W. Burke Avenue

17 (a) Burial (b) Date thereof 1/21/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

JAN 21 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/18/47 19 , at 11 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Evans M.D.
Medical Examiner.
Date signed 1/20/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47732

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 99

Registered No. G47732

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address CAROLINE St
(c) Hospital or institution: ST JOSEPHS HOSPITAL 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10dy
(e) Length of stay in Baltimore (yrs., mos., or days) 80

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 928 E. North Ave NORTH & CECIL AVE 18. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** OTTO DUKER (OTTO HENRY DUKER)

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | |

6 (b) Name of husband or wife: EMMA A. Mehr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-11-67

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 0 | 8 | hr. min. |

9. Birthplace BALTIMORE (Town, county, and state)
10. Usual Occupation PHYSICIAN
11. Industry or business

FATHER
12. Name Henry Duker
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Rose Drescher
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Emma A. Duker
(b) Address 928 E. North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

JAN 21 1947 (a) (Date received by registrar) (b) Huntington Williams M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-19 1947, at 11 40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-18 1947 to 1-19 1947, and that I last saw h.m. alive on 1-19 1947.

| Immediate cause of death | Duration |
|---|---|
| CARDIO-RESPIRATORY FAILURE. | |
| Due to ARTERIO SCLEROSIS GENERALIZED | |
| Due to WITH THROMBOSIS FEMORAL ARTERY | |
| Other Conditions GANGRENE L. LEG | |
| POLY CYTHEMIA VERA | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John B Wells M.D.
Address St Josephs Hosp Date signed 1-20 1947

G17733

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G17733

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address E 44 th. Balto st
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 209 S Stricker st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

**3 (a) FULL NAME** Frank H. Brotzman

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Mr. | Wh. | Widowed |

6 (b) Name of husband or wife Mary E. Brotzman
6 (c) If alive, give age years

7. Birth date of deceased: mo., day, yr. Aug 4 th 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | [illegible] | 5 | hr. min. |

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business —

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Walter Brotzman
(b) Address 3036 Harlem av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 22nd 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md

18 (a) Funeral director A. Jones
(b) Address 501 Hildewood Park Ave (Address) (Undertaker) Huntington Williams MD

JAN 21 1947 (Date received by Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 19, 1947, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1947 to Jan 19 1947, and that I last saw him alive on Jan 16 1947

Immediate cause of death chronic myocarditis — Duration multiple

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Nathan Torrini
Address 206 S Gilmor St. Date signed 1-20-47

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C17731

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. C17731

107

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1308 Rutter St
(c) Hospital or institution: H

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 71

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1308 Rutter St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Reggie Lonnie LIZZIE JONES

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | B | Widowed |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 14, 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 4 | 16 | hr. min. |

9. Birthplace Balto, Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Lonnie Gentry
13. Birthplace Balto, Md

MOTHER
14. Maiden Name Charlotte Gentry
15. Birthplace Balto, Md

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof 1 21 47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director H. H. Gaddis
(b) Address 2401 McCulloh St

JAN 21 1947 (Date received by local registrar) (b) Huntington Williams M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/17/47 19 , at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/16/46 to 1/17/47 19 , and that I last saw h[illegible] alive on 1/17/47 19 .

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia | 3 days |
| Due to Hemorrhage | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature

Address 924 Hollins Date signed 1/20/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G17735

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 52 B

Registered No. G17735

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1134 Scott St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Michael Beine

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| White | Male | Married |

6 (b) Name of husband or wife Mary C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-8-79

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 4 | 10 | hr. min. |

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Retired Fireman
11. Industry or business Balto. City Fire Department

FATHER
12. Name Joseph Beine
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Wagner
15. Birthplace Germany

16 (a) Informant Relative
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 1-22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Ave

19 (a) (b) JAN 21 1947
Date received by Registrar

JAN 21 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18 1947 at 1:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14 1947 to Jan 18 1947 and that I last saw he alive on Jan 18 1947

| Immediate cause of death | Duration |
|---|---|
| Resp. failure | 2 hr. |
| Due to Urinary obstruction | 3 mo. |
| Due to Carcinoma of the bladder | ? Yrs. |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 15 Jan. 47
Major findings of operation: Ca of bladder, infiltrating.
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Willard E. Gordon M. D.
Address J. H. H. Date signed 1-22-47

G47736

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 197

Registered No. G47736

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Belvedere Ave
(c) Hospital or institution: Aged Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Greenspring Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Abrahamy Levenson

3 (b) If veteran, name war —
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widow |

6 (b) Name of husband or wife Fannie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1857

8. AGE: Years 90 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hyman Levenson
(b) Address 2627 E. Monument St

17 (a) Burial (b) Date thereof 1-21-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Plot Rose Bowleys Lane

18 (a) Funeral director Jas. L. Levin Son
(b) Address 1439 E. Baltimore St

19 (a) JAN 21 1947 (b) Huntington Williams, Mort
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 20 1947, at 11.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15 1946, to 1-20 1947, and that I last saw him alive on 1-20 1947.

| Immediate cause of death | Duration |
|---|---|
| Generalized arteriosclerosis | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Edwin Levin
Address Lewisdale Date signed 1/22/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47737

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

122 B

Registered No. G47737

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland
(c) Hospital or institution: Sinai Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9 N. Ann St
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

**3 (a) FULL NAME** Lizzie Solomon

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed.

6 (b) Name of husband or wife Louis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Roumania
(Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name Hirsh Rosenfeld
13. Birthplace Roumania

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (b) Date thereof 1-21-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Park Rd & Hamilton Ave

18 (a) Funeral director Paul Lewis Sons
(b) Address 1439 E Balto St

19 JAN 21 1947 Huntington Williams, M.D.
(Date received) (Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-20- 1947, at A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 1947 to 1-20 1947, and that I last saw him alive on 1-20 1947

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions Post-Operative for excision of adenocarcinoma — Duration 4 wks
(Include pregnancy within 3 months of death)

Date of operation 1-3-47

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elliott T. Weetman, M.D.
Address Sinai Hosp Date signed 1-20-47

VS 150

G47738

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G47738 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 wk.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 S. Edens St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Corinto or Tony Traglia

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 yrs | 1 | | hr. min. |

9. Birthplace S. Giacomo degli Schiavoni (Italy)
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business City Water Dept.

FATHER
12. Name Antonio Traglia
13. Birthplace Italy

MOTHER
14. Maiden Name Concetta Catafesta
15. Birthplace Italy

16 (a) Informant Giuseppe Vitale (Brother)
(b) Address 3066 Kenedy Street

17 (a) Burial (b) Date thereof Jan 22-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Rd Baltimore Md

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 JAN 21 1947 Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 191

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 1/20/ 1947, at 3:55 P.M.

**21.** I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl Fuisinai M.D.
Medical Examiner.
Date signed 1/20/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

G47739 — William Tazwell — G47739

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2015 Mc Culloh St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 Mc Culloh St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Wallace Tazwell

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-22-9861

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | married |

6 (b) Name of husband or wife. Edith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 08 | 7 | 9 | hr. min. |

9. Birthplace Gloucester Co. Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Mary L. Rowe
13. Birthplace Gloucester Co. Va.

MOTHER
14. Maiden Name William Tazwell
15. Birthplace Gloucester Co. Va.

16 (a) Informant Mrs. Edith L. Tazwell
(b) Address 2015 Mc Culloh St.

17 (a) Burial (b) Date thereof Jan. 21, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Gloucester Co. Va.

18 (a) Funeral director Wm. Lewis A. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (b)
(Data taken by registrar) Registrar

JAN 21 1947 Washington, D. C.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/17 - 47 (d) - at 8 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/12 19 47 to 1/17 19 47; and that I last saw h. alive on 1/10/47

Immediate cause of death — Duration

Cerebral Hemorrhage

Due to X Paralysis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2136 Druid Hill Ave Date signed 1/18/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G47740

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 47F

G47710 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1605 Locust St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Locust St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** George W. Cwiek

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6-1909

| 8. AGE: Years | Months | Days | If less than one day hr. | min. |
|---|---|---|---|---|
| 37 | 9 | 14 | | |

9. Birthplace Curtis Bay Md.
(Town, county, and state)
10. Usual Occupation Pipefitter
11. Industry or business

FATHER
12. Name Martin Cwiek
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Pelty
15. Birthplace Poland

16 (a) Informant Mary Cwiek
(b) Address 1605 Locust St.

17 (a) Burial (b) Date thereof Jan 23-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co.

18 (a) Funeral director Wm. S. Fialkowske
(b) Address 2007 Eastern Ave

19 (a) (b)
(Date received by Registrar) (Registrar)

JAN 21 1947 Washington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-20-47 19 at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1-46 19 to 1-20-47 19
and that I last saw him alive on 1-20-47 19
Immediate cause of death Bronchopneumonia
Due to Metastatic Sarcoma
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

| Duration |
|---|
| 6-8 mos |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature R. V. Rangle M.D.
Address 642 Wash. Blvd. Date signed 1-20-47

R. V. RANGLE X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The name is especially important. Physicians: please write the causes of death clearly and legibly.

G47711

G47711

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1727 Lancaster Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1727 Lancaster Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Amelia Sadowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Winnanty

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 68 | Months | Days | If less than one day ....hr. ....min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name —
13. Birthplace Poland

MOTHER
14. Maiden Name —
15. Birthplace Poland

16 (a) Informant Edward Sadowski
(b) Address 1727 Lancaster St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 25-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Mrs. S. Fialkowski
(b) Address 2047 Eastern Ave Huntington Station, Md.

19 (a) Date received JAN 21 1947 (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 21, 1947, at 9 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH arteriosclerotic
Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 1-21-47

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G17742

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 469

G17742 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 217 N. Chester St.
(c) Hospital or institution: 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 217 N. Chester St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Salvatore Testudine

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna
6 (c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr.) Jan 6 1866

8. AGE: Years 81 | Months | Days 14 | If less than one day hr. min. 1866

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation
11. Industry or business Labor

FATHER
12. Name Thomas Testudine
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace Italy

16 (a) Informant Anna Testudine (wife)
(b) Address 217 N. Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-23-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd

18 (a) Funeral [illegible] Meitz & E. Driggs
(b) Address 37 S. Ann St.

19 (a) (Date rec'd by registrar) (b) [illegible]

JAN 21 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1947 at 8:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-19- 1946 to 1-20 1947, and that I last saw h[illegible] alive on 1-19- 1947.

Immediate cause of death Uremia

Duration 1 hour

Due to Carcinoma of Bowels

Duration 2 wks

Due to " "

Duration 1 yr.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. Demarco M. D.
Address Medical Arts Bldg. Date signed 1-20-47

X

G47713

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47713 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 121 Light St.
(c) Hospital or institution: Balto Gen'l Hosp, W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town 3808 Brooklyn Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto - 25 - Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Robert Montgomery.

**3 (b) If veteran, name war**

**3 (c) Social Security Account No.**

**4. Sex** M

**5. Color or race** W.

**6 (a) Single, married, widowed, or divorced.** M

**6 (b) Name of husband or wife**

**6 (c) If alive, give age** years

**7. Birth date of deceased (mo., day, yr.)** Sept 26 1890

**8. AGE:** Years 56. Months 3 Days 23 If less than one day hr. min.

**9. Birthplace** Pa.
(Town, county, and state)

**10. Usual Occupation** Electrician

**11. Industry or business**

**FATHER** 12. Name Harry Montgomery
13. Birthplace Pa.

**MOTHER** 14. Maiden Name Mc Grant ?
15. Birthplace Pa.

**16 (a) Informant** Grace Montgomery
(b) Address 3908 Brooklyn Ave

**17 (a)** Burial (Burial, cremation, or removal) **(b) Date thereof** 1-23-1937 (month) (day) (year)

**(c) Cemetery or crematory** Glen Haven
Location G. A. Co. Md.

**18 (a) Funeral director** Pilgrim & Flanagan
(b) Address 1476 Light St.

**19 (a)** 1-21-1937 (b) by me Wellington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** January 19 1937 at 9:25 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1937 to Jan 19 1937.
and that I last saw deceased alive on Jan 19 1937.

| Immediate cause of death | Duration |
|---|---|
| Hypostatic Congestion Pneumonia | |
| Due to Hypertension Cardiovascular Renal | |
| Due to Uremia | |
| Other Conditions Liver Cirrhosis | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy 1/19/37 Immediate

**PHYSICIAN** Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23. Signature** [illegible] M.D.

Address 121 Light St Date signed 1/19/37

G47711

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G47711 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 14 W. West St.
(c) Hospital or institution: V

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 14 W. West St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles E. Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Flora M. Clark

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25 1880

8. AGE: Years 66 | Months 3 | Days 24 | If less than one day hr. min.

9. Birthplace Calvert County Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER 12. Name Charles E. Clark
13. Birthplace Calvert Co. Md.

MOTHER 14. Maiden Name Mary Young
15. Birthplace Calvert Co

16 (a) Informant Joseph P. Clark
(b) Address 908 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-22-1947 (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location A. A. Co. Md.

18 (a) Funeral director Flanagan & Flannery
(b) Address 414 Light St.

19 (a) 1947 Jan 22 (Date) (b) John Williams, M.D. Registrar

VS 280

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 19 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1946 to Jan. 2 1947, and that I last saw h[illegible] alive on Dec. 3 1947.

| Immediate cause of death | Duration |
|---|---|
| Arteriosclerosis | 4 mos. |
| Cerebral Vascular Disease | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1078 West St Date signed 1/22/47

X

G-47745

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 E

G-47745 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: Monument Street
(c) Hospital or institution: Sinai Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days): 50 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 2233 Eutaw Place
(If rural give location)
(e) Citizen of foreign country?: (Yes or No)
If yes, name country:

**3 (a) FULL NAME:** HATTIE HOFF /

Supplement medical certification issued by Dr. Howard J. Maldeis 1-24-47

3 (b) If veteran, name war: ——

3 (c) Social Security Account No.: ——

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife: ——

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1895

8. AGE: Years: 52 | Months: | Days: | If less than one day: hr. min.

9. Birthplace: Lithuania
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business:

FATHER 12. Name: Abner Hoff
13. Birthplace:

MOTHER 14. Maiden Name: Lipah
15. Birthplace:

16 (a) Informant: Hospital Records
(b) Address:

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-22-47 (month) (day) (year)
(c) Cemetery or crematory: Herring Run
Location: Philadelphia Rd. & Bowleys Lane

18 (a) Funeral director: JACK LEWIS, INC.
(b) Address: 1439 E. Baltimore St.

19 (a) JAN 21 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: January 21 1947, at 5:00AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to er death on the day stated above, and death in my opinion resulted from: natural causes XX, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: *Pulmonary Edema

Other conditions:
Pulmonary edema and congestion
Due to: Coronary heart disease
Fatty change of liver.

Other Conditions: Diabetes mellitus, clinical
Carcinoma of hepatic flexure of colon
with metastasis to lung.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?:
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?:
(d) Means of injury:

23. Signature: Howard J. Maldeis, M.D.
Medical Examiner.
Date signed: 1-24-47

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X over

From autopsy findings, autopsy performed by Dr. Wm. Weinberg.

N.J. Lemmie, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State My (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give)
(d) Street No. 2233 Eutaw
(If rural give location)
(e) Citizen of foreign country? (Yes or)
If yes, name country

3 (a) FULL NAME HATTIE HOFF

3 (b) If veteran, name war —
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | S |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | | | hr. min. |

9. Birthplace Lutherville
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Abner Hoff
13. Birthplace

MOTHER 14. Maiden Name Lipah
15. Birthplace

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (b) Date thereof 1-22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Philadelphia Rd + Rossville Blvd

18 (a) Funeral director Jack Levy Inc
(b) Address 439 E. Baltimore St

19 JAN 21 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/21 1947, at 5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 1947, to 1/21 1947 and that I last saw h[illegible] alive on 1/21 1947

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions Diabetes mellitus, Hypertension, Myocardial failure, Gastrointestinal C'Vomiting

If operation in connection with this illness was performed, state date and indicate whether it was for conditions contributing to death or for some other conditions (e.g., exploratory within 3 months of death)

Date of operation

Major findings of operation None

Autopsy? Yes

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accidental
(b) Date of occurrence 12-24-46 (?)
(c) Where did injury occur? 2233 Eutaw Pl
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? no
(Specify type of place)
(e) Means of injury Slipping + fell to floor
23. Signature Judy Porter
Address Sinai Hosp Date signed 1/24 M. D.

VS 150

G17716 BALTIMORE CITY HEALTH DEPARTMENT G17716

# CERTIFICATE OF DEATH 1937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3130 Ellerslie ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3130 Ellerslie ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Louis Brenner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Sophie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 86 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER 12. Name Laiby
13. Birthplace Russia

MOTHER 14. Maiden Name Goota
15. Birthplace Russia

16 (a) Informant Jessye Brenner
(b) Address 3130 Ellerslie ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-21-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Balto St

19 (a) JAN 21 1947 Huntington Williams, M.D. Address 1331 Madison ave

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-20-1947; at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1946 to Jan 20 1947.
and that I last saw him alive on Jan 20 1947

| Immediate cause of death | Duration |
|---|---|
| Chronic Myocarditis | |
| Due to Arteriosclerotic Cardiovascular Disease | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 1331 Madison Date signed 1-21-47

VS 150

G17717 BC# G17717

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G 50274 108

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address 212 N. Gilmore St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d

(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 212 N. Gilmore St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

**3 (a) FULL NAME** Paul Edward James

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Col. | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 8 | 15 | hr. min. |

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Frank James

13. Birthplace Wilmington N.C.

MOTHER — 14. Maiden Name Pauline Durham

15. Birthplace Wilmington N.C.

16 (a) Informant Frank James

(b) Address 212 N Gilmore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 21 '47 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 922 W. Lexington St.

19 (a) Filed JAN 21 1947 (b) Registrar

V S 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan 19 1947, at 6 0 M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 1/6/47 19 to 1/19/47 19; and that I last saw h(im) alive on 1/19 19 47

Immediate cause of death Lobar Pneumonia — Duration 2 wks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

**23.** Signature R. W. Hamilton M. D.

Address 716 N. Gilmore St. Date signed 1/21/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G17718

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G17718

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 S. Stockton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Bertrude A Gough.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, ~~married, widowed, or divorced~~ |
|---|---|---|
| F. | C | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 14 - 1904

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 42 | 2 | 5 | hr. min. |

9. Birthplace Maryland. (Town, county, and state)

10. Usual Occupation Laundress

11. Industry or business

FATHER
12. Name William Gough
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Handel
15. Birthplace Va.

16 (a) Informant Eunice Green
(b) Address 108 S Stocken St

17 (a) Burial (b) Date thereof Jan. 27, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location

18 (a) Funeral director Mrs Katie R. Williams (b) 822 W. Lafayette Ave

19 (a) JAN 21 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/19 1947, at 1:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature J. J. Lukinski M.D.
Medical Examiner.
Date signed 1/20/47

VS 191

G17749

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G17749 / 1498 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy White King G68604

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John King

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1921

8. AGE: Years 25 | Months 6 | Days 2 | If less than one day hr. min.

9. Birthplace Franklin Va. (Town, county, and state)

10. Usual Occupation Power Machine Operator

11. Industry or business

FATHER 12. Name Richard White

13. Birthplace Warren N.C.

MOTHER 14. Maiden Name Rosabe Mason

15. Birthplace Franklin Va.

16 (a) Informant Richard White Jr.

(b) Address 1413 W. Saratoga

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 23/1947 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem.

Location

18 (a) Funeral director Mrs Kate P. Kilgus

(b) Address 322 W. Lanvale St

19 (a) Date received by registrar JAN 27 1947 (b) Registrar

V S 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/18 1947, at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/15 1946, to 1/18 1947, and that I last saw h-r alive on 1/18 1947

| Immediate cause of death | Duration |
|---|---|
| Acute Multiple embolic pulmonary | 5 days |
| Due to Caucasian Ocation | 1 day |
| Due to Pneumonia - Obesity | 10 days |
| Other Conditions Infection - Puerperal pregnancy | 3 days |

(Include pregnancy within 3 months of death)

Date of operation 1/12/47

Major findings of operation: Pregnancy

of autopsy: refused

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. Louis Jones M.D.

Address 100 Druid Hill Ave Date signed 1/20/47

X

G17750

TN. 98475

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G17750

Registered No. 137a

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-0-8
(e) Length of stay in Baltimore (yrs., mos., or days) ?

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 N. Bruce St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Frank Tuckson

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Col | Widower |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 4th 1860

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 86 | 10 | 15 | hr. min. |

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Tuckson
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah Jackson
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records )

17 (a) Burial (Burial, cremation or removal) (b) Date thereof Jan. 23, 1947 (month) (day) (year)
(c) Cemetery or crematory Laurel Cem.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 21 1947

M. S.-150

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH Jan. 19th 1947 19 , at 6.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 11th 1946 to Jan. 19t 1947, and that I last saw him alive on Jan. 19 1947

| Immediate cause of death | Duration |
|---|---|
| Congestive Heart failure | |
| Due to Hypertensive Cardio - vascular Disease | |
| Due to | |
| Other Conditions Pyelonephritis, Benign Hypertrophy of Prostate | |

(Include pregnancy within 3 months of death)

Date of operation 4-15-46
Major findings of operation: Above
of autopsy: Above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin M. Lacy, M.D.
M. D.
Address Baltimore City Hosp. Date signed 1-20-47

Harry Wright Williams, MD

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M. D. R. 1285-6

G17751

G17751

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH ✓ 83a

1. PLACE OF DEATH ~~903~~

CITY OF BALTIMORE: (No. 903 Cathedral St ✓ St., ..... Ward)

Registered No. —

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S. If of foreign birth? — yrs. — mos. — ds.

2. FULL NAME Bertha Reynolds

(a) Residence: No. 903 Cathedral St St., ..... Ward.

(Usual place of abode) (If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. Color or Race | 5. Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Single |

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, year) April 21 1871

| 7. AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 75 | 9 | 9 22 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Restaurant

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation 40 yrs

12. BIRTHPLACE (city or town) (State or country) Maryland

FATHER

13. NAME Joseph W. Reynolds

14. BIRTHPLACE (city or town) (State or country) Maryland

MOTHER

15. MAIDEN NAME Sarah W. McClenahan

16. BIRTHPLACE (city or town) (State or country) Maryland

17. INFORMANT (Address) Patient - Record at Union Memorial Hosp

18. BURIAL, ~~CREMATION, OR REMOVAL~~ Pat Repost

Place Hopewell Cemetery Date 1/20/47, 19...

19. UNDERTAKER H. F. Means & Sons

(Address) 805 N. Calvert St

20. [illegible] JAN 21 1947 Hugh [illegible] Williams

### MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Jan 13, 1947

22. I HEREBY CERTIFY, That I attended deceased from April 7th, 1936 to Jan 13th 1947

I last saw h[illegible] alive on Jan 12 1947 Death is said to have occurred on the date stated above, at 8 A.m.

The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Cerebral Hemorrhage | Jan 13 47 |
| | |
| | |
| | |

Other contributory causes of importance: None

Name of operation None Date of —

What test confirmed diagnosis? Hem Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? — Date of injury ... 19...

Where did injury occur? — (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place —

Manner of injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? — If so, specify —

(Signed) Robert W. Johnson Jr M. D.

(Address) 4E Madison St Balto

N.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G17752

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G17752

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 415 Homeland ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 Homeland ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anna W. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W. | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/17/1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | | 2 | hr. min. |

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Michael Brown
13. Birthplace Baltimore Co. Md.

MOTHER
14. Maiden Name Sarah Martin
15. Birthplace Maryland

16 (a) Informant My Pauline F. Brown
(b) Address 415 Homeland ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/47 (month) (day) (year)
(c) Cemetery or crematory St Mary's Cemetery
Location Homeland ave

18 (a) Funeral director J. J. Fahey & Sons
(b) Address 31 S Eutaw St.

19 (a) JAN 21 1947 (b)
(Date rec'd by reg.) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/19 1947, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to Jan 19 1947.
and that I last saw her alive on Jan 19 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 1 hr |
| Due to Essential Hypertension | 4 yrs |
| Due to Myo-Carditis | 4 yrs |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert M. Foster M. D.
Address 2824 St. Paul St Date signed Jan 20 1947

X

G47753

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1316

Registered No. G47753

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4006 Tenth St., Brooklyn
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4006 Tenth St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Sarah Katherine Pfeffer

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Levi Pfeffer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 26, 1854

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 92 | 10 | 24 | hr. min. |

9. Birthplace Reisterstown, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Moses Schaeffer
13. Birthplace United States

MOTHER
14. Maiden Name Betty Hildebrandt
15. Birthplace United States

16 (a) Informant Mr. Carroll R. Pfeffer
(b) Address 5009 Wetheredsville Road

17 (a) Burial (b) Date thereof Jan. 22, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Charles Lamborn
(b) Address 4510 Liberty Heights Ave.

JAN 21 1947 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 20 1947 at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 11, 1946, to Jan 20 1947, and that I last saw h alive on Jan 18 1947.

| Immediate cause of death | Duration |
|---|---|
| (a) Chr. Myocarditis. | |
| Due to (b) Chr. Nephritis. | |
| Due to (c) | |
| Other Conditions Senility. | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John E. Shannon M.D.
Address Medical Arts Bldg. Date signed 1/22/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47754

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G47754

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4401 Liberty Heights Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4401 Liberty Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James W. Laidler, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Dorothy A. Laidler
6 (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) November 4, 1908

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 38 | 2 | 15 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Clerk - Asst. Paymaster
11. Industry or business B&O RR.

FATHER
12. Name James W. Laidler, Sr.
13. Birthplace Georgia

MOTHER
14. Maiden Name Margaret A. Kolscher
15. Birthplace Georgia

16 (a) Informant Mrs. James W. Laidler
(b) Address 4401 Liberty Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 22, 1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Mitchell Lawrence
(b) Address 4510 Liberty Heights Ave.

19 (a) JAN 21 1947 (Date rec'd by registrar) (b) Thurlington Wilkinson, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20, 1947, at 12:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1946 to Jan 20 1947
and that I last saw him alive on Jan. 20, 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 2 hrs. |
| Due to Hypertensive C-V. D. | 15 yrs. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Edward Leach M. D.
Address 14 E. Eager St. Date signed 1/20/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

647755

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 647755

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Lutheran Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 919 Scott Street.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
(f) If yes, name country

3 (a) FULL NAME Gloria Louise Wainwright

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1944

8. AGE: Years 2 | Months 8 | Days 11 | If less than one day ..... hr. ..... min.

9. Birthplace Annapolis, Md.
(Town, county, and state)

10. Usual Occupation child.

11. Industry or business

FATHER
12. Name William David Wainwright
13. Birthplace Wilson, North Carolina

MOTHER
14. Maiden Name Henriette Colman.
15. Birthplace Annapolis, Md.

16 (a) Informant Father - Wm Wainwright
(b) Address 919 Scott St. Balto. Md

17 (a) [illegible] (b) Date thereof Jan 22 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie Md.

18 (a) Funeral director Phillips Funeral
(b) Address 1603 N. Eutaw St.

19 (a) JAN 21 1947 (b) Lumington-Williams, Md.
Registrar
(Date received by registrar)

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20 1947, at 3:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 18 1947 to Jan 20 1947.
and that I last saw her alive on Jan 20 1947.

| Immediate cause of death | Duration |
|---|---|
| Circulatory collapse | |
| Due to pneumonia | |
| Due to whooping cough. | |
| Other Conditions Measles, Otitis media, Chronic malnutrition. | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R D Hanson M. D.
Address Lutheran Hospital Date signed 1/22/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

647756

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. 647756

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1328 Etting St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Weeks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Aaron

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-14-97

8. AGE: Years 49 | Months 10 | Days 5 | If less than one day: hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Days Work

11. Industry or business

FATHER
12. Name Eleazy Gittings
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Smith
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-22-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem. Co. Md.
Location

18 (a) Funeral director Jesse W. Redden
(b) Address 436 W. Biddle St.

19 (d) JAN 21 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 19 1947 at 3 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1947 to Jan. 19 1947 and that I last saw her alive on Jan. 19 1947.

Immediate cause of death: Cerebral hemorrhage — Duration 9 da.

Due to: Hypertension — ? yrs

Due to:

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E. Mason M. D.
Address Johns Hopkins Hosp. Date signed 19 Jan '47

VS 150

G47757.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 194a

Registered No. G47757.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1411 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Samuel M. Lauder (Lawder)

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. 217-03-0665

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertie B. Lauder (nee Biggs)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 6 | 28 | hr. min. |

9. Birthplace Balto. Co. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Mayor & City Council

FATHER
12. Name Barrett Lauder
13. Birthplace Balto.

MOTHER
14. Maiden Name -
15. Birthplace -

16 (a) Informant Mrs. Bertie B. Lauder wife
(b) Address 2104 Gwynn Oak Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/47 (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem. Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md. (Huntington-Williams, Mgr.)

19 (a) JAN 21 1947 (Date received by Registrar) (b) Registrar

VS 181

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 20 1947, at 1:45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary occlusion
Generalized arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Heneson M.D.
Medical Examiner.
Date signed 1-20-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G17758

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G17758 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3736 Milford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3726 Milford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ADAM DeBUS

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | no |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Emily E. DeBus (nee Gardner) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 13, 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 3 | 7 | hr. min. |

9. Birthplace Balto. Co. (Town, county, and state)
10. Usual Occupation -
11. Industry or business

**FATHER**
12. Name John H. DeBus
13. Birthplace Balto. Co.

**MOTHER**
14. Maiden Name Bessie E. Bananza
15. Birthplace Balto. Co.

16 (a) Informant Mrs. Adam DeBus wife
(b) Address 3736 Milford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 24 1947 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 20, 1947, at 4:15PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1947 to Jan 20 1947 and that I last saw him alive on Jan 20 1947.

| Immediate cause of death | Duration |
|---|---|
| Acute Coronary Thrombosis | 2 hr |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John J. Abbott M. D.
Address 4509 Liberty Heights Date signed 1-21-47

X

G47759

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G47759

CWK-106681

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 612 E. Pratt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
William Amerson

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widower |

6 (b) Name of husband or wife Edith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5-1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 8 | 26 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Amerson
13. Birthplace Georgia

MOTHER
14. Maiden Name Aurelia Clemmons
15. Birthplace Tennessee

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Loca Johns Hopkins Medical Schoo JAN 21 1947

18 (a) Funeral director Commissioner of Health
(b) Address

JAN 21 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1-1947 19..., at 1 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 19 46 to Jan. 1 19 47, and that I last saw h... alive on Jan. 1 19 47.

| Immediate cause of death | Duration |
|---|---|
| Cer. Ste., fer-adenoma | 10 yrs. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Not Done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Hamb
Address Balt. City Hosp. Date signed 1-8-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47760

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G47760 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2001 N. Hilton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles J. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 71 | Months — | Days — | If less than one day — hr. — min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Vice Pres of Md Life Ins. Co.

11. Industry or business

FATHER
12. Name H. Tillard Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Fannie N. Owens
15. Birthplace Md

16 (a) Informant Miss Fannie N. Smith
(b) Address 2001 N Hilton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Baltimore, Md.

18 (a) Funeral director A. H. Means & Son
(b) Address 805 N. Calvert St

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 22 1947 Huntington Williams, Md

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 1-20 1947, at 12 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 1-19 1947 to 1-20 1947 and that I last saw him alive on 1-20 1947.

| | Duration |
|---|---|
| Immediate cause of death carcinoma pancreas | |
| Due to Myocardial Infarction | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23. Signature** F. A. Shallenberger, Jr. M. D.

Address University Hospital Date signed 1-20-47

X

G 7761

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH (93)

Registered No. G 7761

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 600 Chapel Gate Lane
(c) Hospital or institution: Linthicum Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County N
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3321 St Paul St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Carrie V Nuttall

3 (b) If veteran, name war: N
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Alex Nuttall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb 6 1864

8. AGE: Years 82 | Months 11 | Days 14 | If less than one day: hr. min.

9. Birthplace: Queen Anne Co Md
(Town, county and state)

10. Usual Occupation: Housework

11. Industry or business:

FATHER
12. Name: Wilhom D Lucas
13. Birthplace: Queen Anne Co Md

MOTHER
14. Maiden Name: Louisa Watkinson
15. Birthplace: Md

16 (a) Informant: Charles A Cole
(b) Address: 901 W University Pky

17 (a) Burial: (b) Date thereof 1/22/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory: Greenmount
Location: Baltimore Md

18 (a) Funeral director: Wilhom Cole Son
(b) Address: 1217 St Paul St

JAN 22 1947 (Date rec'd by local registrar) Hunterton Williams M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/20 1947, at 7:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1946 to 1/20 1947, and that I last saw h alive on 1/20 1947.

Immediate cause of death: Cardiovascular Collapse — Duration: 4 days

Due to: Arteriosclerosis Marked without hypertension

Due to:

Other Conditions: Senile dementia Simple type — 2 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: D. T. Williams M.D.

Address: 33 N Paca St Date signed 1/22/47

X

G17762

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G17762 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 978 Fort Ave SE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Joseph Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | married |

6 (b) Name of husband or wife Laura Jackson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1893

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | 1 | 22 | hr. min. |

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Upholsterer
11. Industry or business
12. FATHER Name H. Jackson
13. Birthplace Md.
14. MOTHER Maiden Name Josephine Jackson
15. Birthplace Md.
16 (a) Informant Arthur Holland
(b) Address 223 Jasper St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/47 (month) (day) (year)
(c) Cemetery St. Peter's
Location Md.
18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.
19 JAN 22 1947 Signature for Williams

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 17 1947, at 2:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Kelbach M.D. Medical Examiner.
Date signed Jan 18, '47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G17763

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 B

Registered No. G17763

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 118 S. Morley St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 118 S. Morley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles D. Uhden

3 (b) If veteran, name war None

3 (c) Social Security Account No. 717-07-6351

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary F. Uhden

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Feb 27 1880

8. AGE: Years 66 | Months 10 | Days 24 | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Penna R.R.

FATHER 12. Name Wm E. Uhden

13. Birthplace Germany ?

MOTHER 14. Maiden Name

15. Birthplace Germany

16 (a) Informant Wm E. Uhden

(b) Address 118 S. Morley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 23-1947 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Poll C+B.M. Valley City

18 (a) Funeral director Frath + Sheeler

(b) Address

19 (a) (Date rec'd by registrar) (b) Registrar

VS 2 '47 JAN 22 1947

Huntington Williams

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 20 1947 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2 1946 to Jan 20 1947 and that I last saw him alive on 1-20 1947.

Immediate cause of death Carcinoma of Stomach — Duration 2 mos

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Raymond Miller M.D.

Address 20 30 Wilkens Ave Date signed 1/24/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47764

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 107

Registered No. G47764

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 6400 Sefton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6400 Sefton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country no.

3 (a) FULL NAME Annie Velker

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F. | W. | Widow |

6 (b) Name of husband or wife Andrew J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/3/63

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 4 | 17 | hr. min. |

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At home

FATHER
12. Name John Bishop
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine ?
15. Birthplace Germany

16 (a) Informant William E. Walter
(b) Address 6400 Sefton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave - Balto. Md.

18 (a) Funeral director Lilly & Zeiler Co.
(b) Address 403 S Wolfe St.

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 22 1947 Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1947, to Jan 20 1947, and that I last saw h.. alive on Jan 19 1947.

| Immediate cause of death | Duration |
|---|---|
| Broncho Pneumonia | 5 days. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Janet Fraher M. D.
Address 823 N. Mark. St. Date signed 1/24/47

G17765

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13 B

G17765 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 408 S. Collington Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

**3 (a) FULL NAME** John A. RAKOWSKI

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7-17-1893
8. AGE: Years 53 Months 6 Days 5 4 If less than one day hr. min.
9. Birthplace Balto (Town, county, and state)
10. Usual Occupation press hand
11. Industry or business unemployed
12. FATHER Name Casimir Rakowski
13. Birthplace Balto - Md
14. MOTHER Maiden Name Katherine Jarzynski
15. Birthplace Balto Md
16 (a) Informant (sista)
(b) Address 408 S. Collington Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Rd
18 (a) Funeral director Lilly & Zeiler
(b) Address 503 S. Wolfe St.
19 (a) (Date received by registrar) JAN 22 1947 (b) Huntington Williams, M.D.

VS-15

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 21, 1947, at 5 45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. (Medical Examiner)
Date signed 1/21/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47766

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47766 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 29 E. Fort Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 29 E. Fort Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ROSE A. BAUMANN

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | M |

6 (b) Name of husband or wife Louis Baumann
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) June 27, 1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 6 | 22 | hr. min. |

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John W. Shuffler
13. Birthplace Md.

MOTHER
14. Maiden Name Mary A. Schubbard
15. Birthplace Md.

16 (a) Informant Family
(b) Address 29 E. Fort Ave.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 1/23/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave.
18 (a) Funeral director James L. McCauley.
(b) Address 120 E. Fort Ave
19 (a) (b) Registrar

JAN 22 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 19, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/18/1946, to 1/19/1947, and that I last saw her alive on 1/19/47 19

Immediate cause of death Coronary thrombosis — Duration Imm. mediate

Due to

Due to

Other Conditions Hypertensive cardio vascular disease. — ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Deitel M. D.
Address 1226 Hanover St. Date signed 1/20/47 1947.

G17767

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G17767 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Calvert
(c) City or town St. Leonard (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lois Humphreys

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Vivian Humphreys

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 12, 1920

8. AGE: Years 26 | Months 9 | Days 9 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER 12. Name Lloyd Bowen
13. Birthplace Md.

MOTHER 14. Maiden Name Elizabeth Hardesty
15. Birthplace Md.

16 (a) Informant Floyd Bowen
(b) Address St. Leonards, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 24, 1941 (month) (day) (year)
(c) Cemetery or crematory Waters Memorial
Location Upland Creek, Md.

18 (a) Funeral director R. A. Harkins & Son
(b) Address Mutual, Md.

19 (a) (Date rec'd by Reg.) JAN 22 1941 (b) Huntington Williams, M.D. Registrar

VS-50

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 1-21 1941 at 5:45 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from 1-17 1941 to 1-21 1941 and that I last saw h alive on 1-21 1941

Immediate cause of death: Respiratory failure — Duration

Due to: Peritonitis — Duration

Due to: infected wound of post operative appendix — Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: incised wound of abdominal wall

of autopsy: Cerebral oedema

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. Shadle Jeffers, Jr. M. D.
Address University Hospital Date signed 1-21-41

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G17768

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1310

G17768 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5218 Florence Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5218 Florence Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary F. Weller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Joseph J. Weller

6 (c) If married, give age years

7. Birth date of deceased (mo., day, yr.) June 18, 1872

8. AGE: Years 74 | Months 7 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Jacob Weaver
13. Birthplace Pinkneytown

MOTHER 14. Maiden Name Emma Robinson
15. Birthplace Pinkneytown

16 (a) Informant Mrs Henry Meare
(b) Address 5218 Florence Ave

17 (a) Burial (b) Date thereof Jan 22, 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greenmount
Location Baltimore Md

18 (a) Funeral director Logan Myers
(b) Address 5005 Park Heights Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20, 1947 at 6:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1946, to Jan 20 1947, and that I last saw her alive on Jan 20 1947.

| Immediate cause of death | Duration |
|---|---|
| Uraemia | 1 week |
| Due to Arteriosclerosis Nephritis | |
| Due to Senility | |
| Other Conditions — | |

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation?

of autopsy?

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles J. Wells M. D.
Address 5276 Park Heights Ave Date signed Jan 24 47

VS 150

G47769

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 184

Registered No. G47769

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 Brevard Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** GEORGE T. SKIPWITH, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6-1922

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 25 | | 12 | hr. min. |

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Guard

FATHER
12. Name George T. Skipwith
13. Birthplace Keyesville, Va.

MOTHER
14. Maiden Name Elizabeth Wise
15. Birthplace Unknown

16 (a) Informant George T. Skppwith
(b) Address 1106 Brevard Street

17 (a) Burial (b) Date thereof Jan 23
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto Memorial
Location

18 (a) Funeral director James Hayes
(b) Address 1142 Westwell St

19 (a) (Date rec'd by registrar) JAN 22 1947 Huntington Williams, M.D.

VS 15

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 18, 1947 at 2:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of Heart

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-17-47 at 10 P. M.
(b) Where did injury occur? 1106 Brevard Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 1-20-47

X

50F627.70

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X ✓ 48 B

Registered No. 627.70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos 3 wks.
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Fla. (b) County
(c) City or town W. Palm Beach. (If outside city or town limits, write RURAL and give town)
(d) Street No. 337 Colonial Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Irene Platt

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Klein
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) 1-8-95

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | - | 13 | hr. min. |

9. Birthplace Fla (Town, county, and state)
10. Usual Occupation Home-wife
11. Industry or business

FATHER
12. Name James Peterson
13. Birthplace Fla.

MOTHER
14. Maiden Name Hallulah Tyre
15. Birthplace Fla.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jany 23/47 (month) (day) (year)
(c) Cemetery or crematory Dade City Cem.
Location Dade City, Fla.

18 (a) Funeral director John O. Mitchell Sons
(b) Address [illegible] Eustace Place

19 JAN 24 1947 (Date rec'd by registrar) (b) Registrar

VS 190

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH Jan. 21 1947, at 5.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27 1946 to Jan. 21 1947, and that I last saw him alive on Jan. 21 1947.

| Immediate cause of death | Duration |
|---|---|
| Cachexia | |
| Due to Adenocarcinoma fundus uteri with mets to | |
| Due to liver & lymph glands | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Josephine E. Rendrew, M. D.
Address Johns Hopkins Hosp. Date signed 1/21/47

Huntington Williams, M.D.

X

G17771

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G17771 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd St & Calvert
(c) Hospital or institution: Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 dz
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2428 Barclay St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Cecelia Maguire

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | no |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Mar |

6 (b) Name of husband or wife James Chomer McGuire
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 4 | 9 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Alexander B. Colbert
13. Birthplace Balto

MOTHER
14. Maiden Name Felicia Bedout
15. Birthplace Balto

16 (a) Informant Mrs. Virginia C. Halley
(b) Address 408 E. Lorraine Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JAN 22 1947 (b) Filed (Registrar's Signature) Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1947, at 6:12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-2 1947 to 1-21 1947, and that I last saw her alive on 1-21 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebro-vascular accident | 19 dz |
| Due to Hypertensive Cardio-vascular disease | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
Of autopsy Edema of brain; post pulmonary [illegible]

**PHYSICIAN**
Underline the cause to which death should be assigned statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward H. Jones Jr. M. D.
Address Union Mem. Hosp. Date signed 1-21-47

VS 150

X

G17772

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 163M

G17772 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 510 Richwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 50YRS.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 522 Richwood
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** HUGH A. DIETZ HUGH ALBRIGHT DIETZ

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary M. Dietz
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Sept. 11, 1896
8. AGE: Years 50 | Months 4 | Days 9 | If less than one day hr. min.
9. Birthplace: Havre de Grace, Md. (Town, county, and state)
10. Usual Occupation: Insurance Agent
11. Industry or business: Prudential Insurance Co.

FATHER
12. Name: Alfred J. Dietz
13. Birthplace: York, Pa.

MOTHER
14. Maiden Name: Grace G. Thompson
15. Birthplace: Havre de Grace, Md.

16 (a) Informant: Mrs. Mary M. Dietz
(b) Address: 522 Richwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/47 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) Filed: Huntington Williams Registrar

VS-15 JAN 22 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/20/47 19..., at 7:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Carbon Monoxide Poisoning

Due to Fumes from automobile in garage

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/20 at 7 P.M.
(b) Where did injury occur? Rear of 510 Richwood Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Self Inflicted

23. Signature John R. Weis M.D.
Medical Examiner.
Date signed 1/21/47

X

G47773

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

G47773 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2818 Winchester St.
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2818 Winchester St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ROBERT F. HAHN

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:
4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Bessie Trew Gardner Hahn
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 16, 1893
8. AGE: Years 53 | Months 9 | Days 4 | If less than one day hr. min.
9. Birthplace Balto. Co., Md. (Town, county, and state)
10. Usual Occupation X-Ray Division
11. Industry or business Westinghouse

FATHER
12. Name Robert Hahn
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Sophia Kuhlman
15. Birthplace Unknown

16 (a) Informant Mrs. Bessie T. Hahn Wife
(b) Address 2818 Winchester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 22 (Date received by registrar) (b) 1947 Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 20, 1947, at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11 1947 to 1-20 1947 and that I last saw h[illegible] alive on 1-20 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | 12 hours |
| Angina Pectoris | 10 days |
| Due to | |
| Due to | |
| Other Conditions None | |

(Include pregnancy within 3 months of death)
Date of operation Not done
Major findings of operation:
of autopsy: Not done

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leon Cohen M. D.
Address 1201 Poplar Home St Date signed 1-21-47

VS 150

G17774 ✓ G17774

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2703 Goodwood Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2703 Goodwood Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ANNA B. DOWNES

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Oliver C. Downes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 31, 1858

8. AGE: Years: 88 | Months: 2 | Days: 19 | If less than one day: hr. min.

9. Birthplace: Dover, Del.
(Town, county, and state)

10. Usual Occupation: -

11. Industry or business

FATHER
12. Name: John Seward
13. Birthplace: Del.

MOTHER
14. Maiden Name: Martha Hawkins
15. Birthplace: Del.

16 (a) Informant: Mrs. Bertha E. Hayes
(b) Address: 2703 Goodwood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date received by Registrar) JAN 24 1947 Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20, 1947, at 9:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3 1945 to Jan 20 1947. and that I last saw HER alive on Jan 20 1947.

| | Duration |
|---|---|
| Immediate cause of death: Arteriosclerotic Heart Disease | 2 yrs. |
| Due to: Generalized Arteriosclerosis | 5 yrs. |
| Due to: | |
| Other Conditions: Chronic nephritis (Include pregnancy within 3 months of death) | 7 yrs. |

Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: George Dawson M. D.
Address 4808 Harford Rd Date signed 1/27/47

Huntington Williams, M.D.

937

G17775

CWK-105324

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

106 B

Registered No. G17775

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 126 S. Bond Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Benson

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 28-1905

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 41 | 1 | 17 | hr. min. |

9. Birthplace Georgia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Benson
13. Birthplace ?

MOTHER
14. Maiden Name Ellen Glover
15. Birthplace Georgia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 1/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy Allstorm
(b) Address 5000 Brand Lane

19 (a) JAN 22 1947 Registrar
(Date received by registrar)

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 19 47 at 11.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1946 to Jan. 15 1947 and that I last saw him alive on Jan. 15 1947.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Tuberculosis | 5 mos |
| Due to Bronchopneumonia, | 3 mos |
| Bilateral | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:
23. Signature J. Hutchinson Jr
Address Balt. City Hospitals Date signed 1/24/47

Huntington Williams, M.D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G47776

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

937 V

Registered No. G47776

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins b
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 210 Beale Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Elias Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | M. |

6 (b) Name of husband or wife Mary V. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | | | hr. min. |

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER — 12. Name Unknown
13. Birthplace "

MOTHER — 14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mary V. Smith
(b) Address 210 Beale Court.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Bloomfield ave

19 (a) (Date rec'd by Registrar) JAN 22 1947 (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/19/47 19..., at 11:20 M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John L. Carr M.D.
Medical Examiner.
1/19/47

VS 151

G47777 ✓ G47777

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 170c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 923 N. Gilmor Street
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore ✓
(If outside city or town limits write RURAL and give town)
(d) Street No. 923 N. Gilmor Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E. TABBS ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Colored | Widow |

6 (b) Name of husband or wife Laura S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 7, 187[illegible]

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 1 | 13 | hr. min. |

9. Birthplace Howard County, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Marie Tabbs
(b) Address 923 N. Gilmore St.

17 (a) Burial (b) Date thereof Jan 24 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location

18 (a) Funeral director Wm. Kelly R. Williams
(b) Address 322 N. Schroeder St.

19 (a) JAN 22 1947 Registrar Williams M.D.

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 29 1947 at 7 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia

Due to Fractured rt. tibia and fibula

Other Conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 1-16-47 at 10:10 P.M. Howard Co.
(b) Where did injury occur Route #1 Elkridge Md.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Pedestrian struck by auto.

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 1/30/47

X

G17778

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G17778 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 442 Walton Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Hannah R. Kitchen

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | C | Married |

6 (b) Name of husband or wife Claude J. Kitchen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2 1906

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 41 | - | 17 | hr. min. |

9. Birthplace S.C. (Town, county and state)
10. Usual Occupation School Teacher
11. Industry or business
FATHER 12. Name Thomas C. Randolph
13. Birthplace S.C.
MOTHER 14. Maiden Name Elsie Harrison
15. Birthplace S.C.
16 (a) Informant Claude J. Kitchen
(b) Address 442 Walton Court
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 24, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location
18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 1182 Edmondson Ave.
19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 181

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/19 1947, at 8 20 M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocarditis
Hypertension
Due to
Other Conditions Obesity
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. P. Truitt (Medical Examiner.) M.D.
Date signed 1/20/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G17779

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G17779 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 505 Gold St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** John H. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-3705

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Negro | Married |

6 (b) Name of husband or wife Serita Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 18, 1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | | 1 | hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business Merchants Club

FATHER
12. Name Henry Thomas
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ellen Muse
15. Birthplace W. Moreland Co., Va.

16 (a) Informant Serita W. Thomas
(b) Address 505 Gold St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-23-47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Arbutus, Md.

18 (a) Funeral director Charles R. Law
(b) Address 802 Mad. Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

JAN 22 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 19 1947, at 6:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 18 1947 to Jan 19 1947, and that I last saw him alive on Jan 19 1947

| | Duration |
|---|---|
| Immediate cause of death: Myocardial Infarction | 3 days |
| Due to: Coronary Thrombosis | |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert L. Jackson M. D.
Address 600 N Arlington Ave Date signed 1-21-47

G17780

BALTIMORE CITY HEALTH DEPARTMENT

CWK-107415

# CERTIFICATE OF DEATH 937

Registered No. G17780

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 306 E. 20½ Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
William Fincher

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?? 1900

8. AGE: Years 47 | Months ? | Days ? | If less than one day hr. min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Charles Fincher
13. Birthplace South Carolina

MOTHER
14. Maiden Name Nannie Jones
15. Birthplace South Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director George G. Kelson
(b) Address 1303 Presstman St.

19 (a) JAN 22 1947 Registrar Huntington Williams M.D. Registrar

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 20 19 47, at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 8 19 47, to Jan. 20 19 47, and that I last saw h... alive on Jan. 20 19 47.

| | Duration |
|---|---|
| Immediate cause of death: Bronchopneumonia, aspiration | 5 days |
| Due to: Cerebral Thrombosis + Hemiplegia | 3 mo. |
| Due to: Antemortem Acute Heart Dilation | yrs. |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Robinson Jr
Address Balt. City Hosp. M. D.
Date signed 1/21/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G17781

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 195E

G17781 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1735- W. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** WILLIAM R. WASHAM

3 (b) If veteran, name war: World War 1—
3 (c) Social Security Account No. 213-26-2262

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | married |

6 (b) Name of husband or wife: Edna Rosalie Washam
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/23/1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 2 | 27 | hr. min. |

9. Birthplace Charlotte, North Carolina (Town, county, and state)
10. Usual Occupation Florist
11. Industry or business

FATHER
12. Name Thomas L. Washam
13. Birthplace North Carolina

MOTHER
14. Maiden Name Margaret ann Emerson
15. Birthplace North Carolina

16 (a) Informant Edna Rosalie Washam
(b) Address 1735 W. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/47 (month) (day) (year)
(c) Cemetery or crematory U.S. National
Location Balto. Md.

18 (a) Funeral director Geo. L. Schuval
(b) Address 2151 Fredk. Ave.

JAN 22 1947 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 20, 1947, at 9.15 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fractured skull
Intracranial hemorrhage
Intracerebral hemorrhage
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 20/5
(a) Date of injury 1-19-47 at 2.50 a. M.
(b) Where did injury occur? Found: Frederick Ave near Ellicott Driveway
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found on sidewalk

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 1-22-47

X

G17782

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G17782

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd. & Guilford Ave.
(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 23
(e) Length of stay in Baltimore (yrs., ~~mos., days~~) 67

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 ELMHURST Rd.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES MORRISON HARRIS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| MALE | WHITE | MARRIED |

6 (b) Name of husband or wife LOUISE N. HARRIS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 3, 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 5 | 14 | hr. min. |

9. Birthplace MARYLAND
(Town, county, and state)
10. Usual Occupation LAWYER
11. Industry or business

FATHER
12. Name W. HALL HARRIS
13. Birthplace MARYLAND

MOTHER
14. Maiden Name ALICE PATTERSON
15. Birthplace MARYLAND

16 (a) Informant HOSPITAL RECORDS
(b) Address 33rd. & Guilford Ave., City.

17 (a) Burial (b) Date thereof Jan 24 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry A. Justis & Bro
(b) Address McCulloh & Orchard Sts

(a) JAN 22 1947 (b) Huntington Williams M.D.
(Date received by registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH JAN. 22, 1947, at 8:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from DEC. 31, 1946, to JAN. 22, 1947, and that I last saw him alive on JAN. 22, 1947.

Immediate cause of death CARDIAC DECOMPENSATION — Duration 24 hrs.

Due to ARTERIOSCLEROTIC HEART DISEASE — Duration ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. H. Yeldell M.D.
Address U. M. H. Date signed 1/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Be sure to state the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47783

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

G47783 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument St & Rutland Ave
(c) Hospital or institution Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 26yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2544 Quantico Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Simon Kwash

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Leah Kwash

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace Rumania (Town, county, and state)

10. Usual Occupation Furrier

11. Industry or business

FATHER 12. Name Isaac –
13. Birthplace Rumania

MOTHER 14. Maiden Name Sylve –
15. Birthplace Rumania

16 (a) Informant Mrs. Kwash
(b) Address 1652 Linkton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-22-47 (month) (day) (year)
(c) Cemetery or crematory Bredell
Location

18 (a) Funeral director Jacheiva Bro
(b) Address 1439 E. Balto St

19 (a) JAN 22 1947 (Date rec'd by registrar) Huntington Williams

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-21 1947 at 11 55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-18 1946 to 1-21 1947 and that I last saw him alive on 1-21 1947

Immediate cause of death: Cerebral Vascular Accident — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan B. Herman M. D.
Address Sinai Hospital Date signed 1-22-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G17784 ✓ G17784

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93c

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1902 Boone Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1902 Boone Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3.(a) FULL NAME** Marie Montgomery

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | - | - | hr, min. |

9. Birthplace (?)
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Harry Montgomery
13. Birthplace (?)

MOTHER
14. Maiden Name Margaret
15. Birthplace (?)

16 (a) Informant Mrs. M. Bellman
(b) Address 1902 Boone Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/21/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral City
Location

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVENUE & 22ND

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

JAN 23 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18th 1947, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1/ 1946 to 1/18/ 1947
and that I last saw h[illegible] alive on 11/17/1946

| Immediate cause of death | Duration |
|---|---|
| Unspecified Senility | 1 mo |
| Due to | |
| Unspecified | 1 year |
| Due to | |
| Other Conditions Hypertension, Arteriosclerosis, Chronic Nephritis | 10 yrs |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. Mackin
Address 532 E 22nd St Date signed 1/[illegible]/47

X

G17785

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 307

G17785
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1531 Montpelier St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Elkner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife KATE M. LOHREY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 24-1887

8. AGE: Years 59 | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace NEW. YORK
(Town, county, and state)

10. Usual Occupation WOOD. SHOP.

11. Industry or business GLEN. L MARTIN Co

FATHER
12. Name ADOLPH
13. Birthplace NEW. YORK.

MOTHER
14. Maiden Name M. WANNAMAKER
15. Birthplace NEW. YORK.

16 (a) Informant WIFE
(b) Address 1531 MONTPELIER ST

17 (a) BURIAL (b) Date thereof 1/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory NEW YORK. NY
Location

18 (a) Funeral director Clayton F. Hoffman
(b) Address 1639 Bradford Huntington Williams, M.D.

19 (a) 2 1947 (b) Registrar
(Filed by registrar)

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20, 1947 at 10.24 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cirrhosis of liver
Syphilitic aortitis
Duration Edema of lungs.
Esophageal varices

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-16-47 ?
(b) Where did injury occur? Glenn L. Martin Plant
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Struck by a beam

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 1-21-47

(OVER)

G17786

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G17786 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2734 N. Calvert St.
(c) Hospital or institution: 700 East Preston

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2734 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Edwin Henry Haskins

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W. | Married |

6 (b) Name of husband or wife Mary L. Haskins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 8 | 9 | hr. min. |

9. Birthplace Hagerstown, Oregon
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business U.S. army Colonel.

FATHER
12. Name Wm. S. Haskins
13. Birthplace

MOTHER
14. Maiden Name Mary A. Askin
15. Birthplace Belleville Canada.

16 (a) Informant Mrs. M. L. Haskins
(b) Address 2734 N. Calvert St.

17 (a) Burial (b) Date thereof 1/23/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington National
Location Arlington Va.

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Av.

19 (a) JAN 22 1947 (b) Arlington Williams, Registrar
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 1-20- 1947, at 12:30 P.M.

**21.** I certify that I took charge of the remains described above, held an Autopsy & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

**23.** Signature Homer J. Campbell M.D.
Medical Examiner.
Date signed 1-20-47

VS 191

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G17787

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G17787 / 61

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 503 Washburn Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 Washburn Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Edmund I Upton

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Mary R

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) (9-3 1885 ?)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 4 | 18 | ? hr. min. |

9. Birthplace Balto Co (Town, county, and state)

10. Usual Occupation Foreman Retired

11. Industry or business

FATHER
12. Name Josauha
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mary R Upton
(b) Address 503 Washburn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof I-24-47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Baltimore Hgwy

18 (a) Funeral director Edward Lowbury
(b) Address 339 Ware Ave Huntington Williamsport Md

(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan-21 1947, at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-10 1946 to Jan. 21 1947, and that I last saw h[illegible] alive on Jan. 15 1947

| Immediate cause of death | Duration |
|---|---|
| Acute Coronary Occlusion | Jan. 21, 1947 |
| Due to Cerebro-vascular Sclerosis | |
| Due to Cardiac-Vascular Disease | |
| Other Conditions Diabetes Mellitus | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature 320 Chitwood Ave Paul Lubin M.D. M. D.
Address Date signed

937 1/24/47

VS 150

G17788 BCH- G-16478 BALTIMORE CITY HEALTH DEPARTMENT G17788

# CERTIFICATE OF DEATH 157E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 113 N. Front St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Hale Beaty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: ~~Male~~ Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-6-45

8. AGE: Years 2 | Months - | Days 15 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Beaty
13. Birthplace Ohio

MOTHER 14. Maiden Name Natalie Phillips
15. Birthplace Ohio

16 (a) Informant Relative
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 23rd 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo S. Leach
(b) Address 1201-03 N. Pattinson Park Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1947 at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1947 to Jan 21 1947 and that I last saw him alive on Jan 21 1947

| | Duration |
|---|---|
| Immediate cause of death: Cardiac Arrest | |
| Due to: Congenital heart disease | |
| Due to: Pulmonary stenosis | Life |
| Other Conditions: Three chambered heart | |

(Include pregnancy within 3 months of death)

Date of operation 1/21/47

Major findings of operation: Pulmonary stenosis

of autopsy: As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry T. Behrman

Address Johns Hopkins Hosp. Date signed 1/21/47
M. D.

JAN 22 1947 Huntington Williams, M.D.

X

Dr. D. Lockard
602 Cathedral

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. C17789

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 6028 Old Harford Road
(c) Hospital or institution:
Beech Hill Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 months
(e) Length of stay in Baltimore (yrs., mos., or days) 9 months 1 day

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 939 Franklin (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Ella H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 8 | 16 | hr. min. |

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation unemployed
11. Industry or business

FATHER
12. Name Samuel S. Smith
13. Birthplace Pa.

MOTHER
14. Maiden Name Sarah Kauffman
15. Birthplace Pa.

16 (a) Informant Mrs. Thomas Biddison
(b) Address 5807 Kipling Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/47 (month) (day) (year)
(c) Cemetery or crematory Charles Evans
Location Reading, Pa.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date received by Registrar) JAN 22 1947 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22, 1947, at 12.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 16 Jan 1947 to 22 January 47 and that I last saw him alive on 21 Jan 1947

| | Duration |
|---|---|
| Immediate cause of death Cerebral hemorrhage | 7 days |
| Due to Arteriosclerosis | 9 years |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy none

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide none
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Douglas Lockard, M. D.
Address 602 Cathedral St. Date signed Jan. 23, 47

VS 150

Thomas Hampton Williams, M.D.

X

G17790

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X G17790 Registered No. 157E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County.....
(c) City or town Howard (If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 Cleveland (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

**3 (a) FULL NAME** Marilou Binder

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1-26-29

8. AGE: Years 17 | Months 11 | Days 27 | If less than one day ..... hr. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation.....

11. Industry or business.....

FATHER
12. Name Casper Binder
13. Birthplace Ill

MOTHER
14. Maiden Name Helen Baden
15. Birthplace Ill

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/47 (month) (day) (year)

(c) Cemetery or crematory Evergreen Memorial
Location Balto. Md.

18 (a) Funeral director Fred C. Mitchell & Son
(b) Address 1900 Eutaw Place

19 (a) Huntington Williamsport (Date received by registrar) JAN 22 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1947 at 10:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1947 to Jan 22 1947 and that I last saw him alive on Jan 22 1947

Immediate cause of death: Cardiac arrest — Duration: Min.

Due to: Congenital heart disease — Duration: Life

Due to: .....

Other Conditions: Dyspnoea, Tetralogy of Fallot. (Include pregnancy within 3 months of death)

Date of operation 1/22/47

Major findings of operation: Tachycardia, cyanosis

of autopsy:.....

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Henry L. Bahnson M. D.
Address Johns Hopkins Hospital Date signed 1/27/47

X

G17791 G17791

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland ✓
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: The Petron Institute
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-5-13
(e) Length of stay in Baltimore (yrs., mos., or days) about 16 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6420 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? ~~~ (Yes or No)
If yes, name country

**3 (a) FULL NAME** Brother Thomas F. Burns, S.J.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife ~~~

6 (c) If alive, give age ~~~ years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1877

8. AGE: Years 69 | Months 1 | Days 27 | If less than one day: hr. min.

9. Birthplace Philadelphia, Pa. (Town, county, and state)

10. Usual Occupation Jesuit Lay brother

11. Industry or business

MOTHER | FATHER

12. Name Anthony Burns

13. Birthplace County Cavan, Ireland

14. Maiden Name Annie Gormgan

15. Birthplace County Cavan, Ireland

16 (a) Informant The Petron Institute

(b) Address 6420 Reisterstown Rd., Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/47 (month) (day) (year)

(c) Cemetery or crematory Woodstock

Location Woodstock Md.

18 (a) Funeral director M. W. Meade and Son

(b) Address 505 N. Calvert St.

JAN 22 1947 (Date rec'd by registrar) (b) Hyattsville, Williamsport, Md.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 21 1947, at 6:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-8 1931, to 1-21 1947, and that I last saw h... alive on ... 19...

| Immediate cause of death | Duration |
|---|---|
| repeated myocardial infarct | |
| Due to arteriosclerosis | 2 yrs. |
| Due to | |
| Other Conditions paranoid condition | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature ... M. D.
Address (Physician signing)

VS 150

G17792

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G17792 Registered No. 1228

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Va. (b) County Lewisetta
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Harris, Alexandria

3 (b) If veteran, name war: --
3 (c) Social Security Account No. 223-16-2170

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | col | Married |

6 (b) Name of husband or wife: Julia Haymer Harris
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Dec. 1, 1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | 1 | 20 | hr. min. |

9. Birthplace: St. Mary's County, Md. (Town, county, and state)
10. Usual Occupation: Deckhand
11. Industry or business: Seafarer

FATHER
12. Name: Henry Harris
13. Birthplace: St. Mary's County, Md.

MOTHER
14. Maiden Name: Annie Forest
15. Birthplace: St. Mary's County, Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-25-47 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cem
Location St. Mary's Md

18 (a) Funeral director Dodge D. Nelson
(b) Address 1303 Presstman St

19 1947 (b) (Date received by registrar)

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan. 21 1947, at 9:25 PM

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan. 20 1947 to Jan. 21 1947 and that I last saw him alive on Jan. 21 1947.

| | Duration |
|---|---|
| Immediate cause of death (1) Intestinal obstruction, postoperative state | FEW HOURS |
| Due to (2) Pulmonary atelectasis | 24 HOURS |
| Due to bilateral | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 1-21-47
Major findings of operation: Adhesive bands
of autopsy: As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23.** Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 1/22/47

VS 150

Huntington Williams M.D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G17793

BALTIMORE CITY HEALTH DEPARTMENT X

# CERTIFICATE OF DEATH √166

G17793 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State California (b) County
(c) City or town Alhambra
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 Commonwealth Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Milford M. Davis

3 (b) If veteran, name war

3 (c) Social Security Account No. 554-22-7307

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | White | Single |

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1921

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 25 | 2 | 20 | hr. min. |

9. Birthplace Ridge, Tenn.
(Town, county, and state)
10. Usual Occupation merchant Seaman
11. Industry or business

FATHER
12. Name John L. Davis
13. Birthplace Ridge, Tenn.

MOTHER
14. Maiden Name Elizabeth Walker
15. Birthplace Arkansas

16 (a) Informant Elizabeth Walker
(b) Address Alhambra, Cal.

17 (a) Burial (b) Date thereof 1-28-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director Martin J. Connors
(b) Address 1500 Hollins St.

19 (a) (Date rec'd by registrar) (Signature) Thos. J. Williams M.D. Registrar

JAN 28 1947

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** January 13, 1947 at 3 40 A. M

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gunshot wound of brain

Due to

Other Conditions
(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/13/47 at 3:25 A. M.
(b) Where did injury occur? Dolphin Street near corner of Pace
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Firearms

**23.** Signature Howard J. Mencio M.D.
Medical Examiner
Date signed 1/13/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G17791

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1470

G17791

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Carroll
(c) City or town Finksburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. RFD #1
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Doris Brothers (Wife) 24122

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband ~~or wife~~: Oscar
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 6, 1917
8. AGE: Years 29 | Months 6 | Days 14 | If less than one day hr. min.
9. Birthplace Baltimore, Baltimore, Maryland (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Hiram Bullen
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Habkemeyer
15. Birthplace Md.

16 (a) Informant Oscar Brothers
(b) Address Hampstead Carroll Co.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 23/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Reisterstown Rd.

18 (a) Funeral director John A. McNair
(b) Address 5010 E. Baltimore St.

19 JAN 23 1947 (Date received by registrar) Clayton Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 20 JAN 1947, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 18 JAN 1947, to 20 JAN 1947, and that I last saw her alive on 20 JAN 1947.

| Immediate cause of death | Duration |
|---|---|
| (a) Acute ~~Yellow Atrophy~~ Toxic Hepatitis | 3 days. |
| Due to: (b) Gas Bacillus Infection | |
| Due to: | |
| Other Conditions: Post Operation | 2 days |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Gas Bacillus infection

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Finksburg, Md. Date signed 1/29/47

G17795

G17795

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1640

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 408 N. Kenwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 408 N. Kenwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Milton J. Bertholdt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | married |

6 (b) Name of husband or wife Mildred
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1903

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 43 | 8 | 19 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Truck

FATHER
12. Name Conrad Bertholdt
13. Birthplace Baltimore

MOTHER
14. Maiden Name Minnie Klinger
15. Birthplace Baltimore

16 (a) Informant Mildred Bertholdt
(b) Address 408 North Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O. Fonnell Rd.

18 (a) Funeral director John C. Moran
(b) Address 3 E. Baltimore St.

19 (a) JAN 23 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 21, 1947, at 2 10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH asphyxiation
due to hanging

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death fill in the following:
(a) Date of injury 1-21-47 at 1 30 P. M.
(b) Where did injury occur? 408 N. Kenwood Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Hanging from banister in second floor

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 1-21-47

VS 191

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G17796 — BALTIMORE CITY HEALTH DEPARTMENT — G17796

# CERTIFICATE OF DEATH 94a

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Bal (If outside city or town limits, write RURAL and give town)
(d) Street No. 3411 Elmley Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Charles De Salliford

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | |

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 44 | | | hr. min. |

9. Birthplace Chattanooga Tenn. (Town, county, and state)
10. Usual Occupation Railroad Engineer
11. Industry or business Railroad

FATHER
12. Name John De Salleford
13. Birthplace France

MOTHER
14. Maiden Name Mary molesworth
15. Birthplace Des Moines Iowa

16 (a) Informant Mrs. Wm. H. Morgan
(b) Address 3411 Elmley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 26 45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Wm. Cook Inc
(b) Address 1217 St Paul Street

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 23 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-22 1947, at 8:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19 1947 to 1-22 1947, and that I last saw him alive on 1-22 1947.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Pneumonitis, left Pulmonary oedema | |
| Due to Myocardial infarction | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. A. Shallenberger Jr. M. D.
Address University Hospital Date signed 1-22-47

G17797 G17797

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 467

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 123 W. Read St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 → 2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 123 W. Read St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Eva Fyffe

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~ |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Robert W. Fyffe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, y Aug 27th 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 4 | 25 26 | hr. min. |

9. Birthplace Mt. Vernon N.Y.
(Town, county, and state)
10. Usual Occupation at Home
11. Industry or business —

FATHER
12. Name Unknown (Schutz
13. Birthplace N.Y.

MOTHER
14. Maiden Name (Mary) Unknown
15. Birthplace N.Y.

16 (a) Informant Doris Fyffe
(b) Address 123 W. Read St

17 (a) Burial (b) Date thereof 1/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md

18 (a) Funeral director William Ott Inc
(b) Address 127 St Paul St.

19 (a) (b)
(Date received by) • Registrar

JAN 23 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22nd 1947, at 4 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947, to Jan 22 1947, and that I last saw h alive on Jan 22 1947.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of Rectum | |
| Due to — | |
| Due to — | |
| Other Conditions Arteriosclerosis | |

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
of autopsy —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis J Gross M. D.
Address 836 Wilkens Ave Date signed X 1/22/47

G17798

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 94a

G17798 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 George Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** LEROY D. STONE Sr.

3 (b) If veteran, name war: W. W. I
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife: Florence L Stone
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 10 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 11 | 11 | hr. min. |

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: Carpenter
11. Industry or business: Md. Drydock

FATHER
12. Name (Unknown) Stone
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant: LeRoy D. Stone Jr.
(b) Address: 313 George Ave. Essex, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/47 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet
Location: Balto. Md.

18 (a) Funeral director: William Cook, Inc.
(b) Address: 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Md. Registrar

JAN 23 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/21/1947 at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/21/1947 to 1/21/1947, and that I last saw h[illegible] alive on 1/21/1947.

| Immediate cause of death | Duration |
|---|---|
| Ventricular standstill | |
| Due to Coronary Thrombosis | |
| Due to Myocardial Infarction | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Duncan Clark M. D.
Address Univ. Hosp. Date signed 1/22

X

G17799

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1312

G17799 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 801 Bureau St 16-4
(c) Hospital or institution: Balto. City Jail Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 842 Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Edwin Randolph Carlyle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) ~~Single, married, widowed, or~~ divorced. Single Divorced

6 (b) Name of ~~husband or~~ wife Beulah Carlyle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23rd 1892

8. AGE: Years 54 | Months 6 | Days 22 | If less than one day hr. min.

9. Birthplace Balto. Maryland (Town, county, and state)

10. Usual Occupation Steam Fitter

11. Industry or business Journeyman

FATHER 12. Name Lewis K. Carlyle
13. Birthplace Md.

MOTHER 14. Maiden Name Florence M. Worley
15. Birthplace Md.

16 (a) Informant Mrs. Dyke Hulton Ave.
(b) Address ~~Her son~~ 842 Fulton Ave.

17 (a) Burial (b) Date thereof 1/24/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) JAN 23 1947 (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 15 1947, at 7.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/25 1946 to Jan 15 1947 and that I last saw h~~im~~ alive on Jan 15 1947.

Immediate cause of death Cardiac failure — Duration

Due to

Due to

Other Conditions Pulmonary tuberculosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. N. MacMurchy M. D.
Address 801 Bureau St. Date signed 1/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47809

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. 1730-1

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4308 Arizona Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-1
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4308 Arizona Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sidonie Marie Theresa Wagner.

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: F.
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Charles Edward Wagner
6 (c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1873

8. AGE: Years 73 74 | Months 1 | Days 29 28 | If less than one day ____ hr. ____ min.

9. Birthplace Germany. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Julius Schreiner
13. Birthplace Germany.

MOTHER
14. Maiden Name UNKNOWN.
15. Birthplace Germany

16 (a) Informant Mr. Julius Wagner
(b) Address 3403 Norman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/23/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood cemetery
Location Baltimore, Maryland

16 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) JAN 23 1947 (b) Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21 1947, at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 4 1946, to 1-20- 1947, and that I last saw her alive on 1-20 1947.

Immediate cause of death: Myocardial insufficiency — Duration: 2 months
Due to: Cardiovascular disease — many years
Due to:
Other Conditions: Arteriosclerosis, Cardiac hypertrophy
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Max R. English M. D.
Address 5713 Belair Rd. Date signed 1-21-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G17801 / 107

Registered No. G17801

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4300 Carleview Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28-2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4300 Carleview Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSE LEE ARMSTRONG

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife: Thomas Henry Armstrong

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1861

8. AGE: Years 85 | Months 4 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: James Bull
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Elizabeth Bell
15. Birthplace: Virginia

16 (a) Informant: Mrs. W.S. Warrington
(b) Address: 4300 Carleview Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC
(b) Address: NORTH AVE. & BROADWAY

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 31 1947, at 4.10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1947 to Jan 21 1947.
And that I last saw h[illegible] alive on Jan 20 1947.

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia | 1 week |
| Due to Senility | |
| Due to Cardiac Insuff. Arteriosclerosis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bernard Cohen M. D.
Address 1 Mallard Ct. Date signed 1/24/47

VS 15 JAN 23 1947

Burial Permit Issued

G17803
CWK-107611

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G17803
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 10-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 75- 5- 27-

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 948 Ashland Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Wyman Francis Washburn

3 (b) If veteran, name war: WW I
3 (c) Social Security Account No.: None

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife: Leila (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23-1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 5 | 27 | 21 hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Wyman Washburn
13. Birthplace Massachusetts

MOTHER
14. Maiden Name Anna Cunningham
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Tillman & Son Inc
(b) Address 1219 & 1221 Park Ave.

19 (a) (Date rec'd by registrar) (b) Kensington, Williamson, M.D.

JUN 23 1947 Medical Examiner's Approval

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 20-1947 19 , at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 14 1947, to Jan. 20 1947, and that I last saw him alive on Jan. 20 1947.

| Immediate cause of death | Duration |
|---|---|
| Fat embolism, Rt. lower lobe | 1 day |
| Due to Intratrochanteric fracture left femur | 6 days |
| Due to Subdural hematoma old | over 1 mo. |
| Other Conditions Hypertension, Rt. Arteriosclerosis, general (Include pregnancy within 3 months of death) | yrs |

Date of operation 0
Major findings of operation: 0
of autopsy: as above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 10/2
(a) Accident, suicide, or homicide accident.
(b) Date of occurrence 1-13-47 about 9: A M
(c) Where did injury occur? Balto Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? (Specify type of place)
(e) Means of injury: Slipped & fell down flight of stairs

23. Signature Thomas Orrell, M.D.
Address Balto. City Hosp. Date signed 1-22-47

X

G17803

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G17803 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2468 Greenmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-3
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2468 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anna Schabb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Max

13. Birthplace Russia

MOTHER 14. Maiden Name Ettel

15. Birthplace Russia

16 (a) Informant Morris Schabb

(b) Address 2468 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-23-47 (month) (day) (year)

(c) Cemetery or crematory

Location Mt Zion Herring Run

18 (a) Funeral director Jack Lewis Inc

(b) Address 1609 E Baltimore St

19 (a) (Date rec'd by registrar) (b) Registered

VS 150 JAN 23 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-22-1947; at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1 1944 to Jan 22 1947. and that I last saw h[illegible] alive on Jan 21 1947

| Immediate cause of death | Duration |
|---|---|
| Acute Coronary | 2 weeks |
| Due to Arterio Sclerosis | |
| Due to Chronic coronary disease | 2 yrs |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bernard Cohn

Address Marlborough Date signed 1-23-47 M. D.

X

G17802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 153

G17801 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4934 Pennington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 5
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4934 Pennington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Amelia A. Sexton

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Dennis S.
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Dec 5, 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 61 | 1 | 15 | hr. min. |

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation House work
11. Industry or business at home

FATHER
12. Name Charles Wilson
13. Birthplace Sweden

MOTHER
14. Maiden Name Unknown
15. Birthplace Sweden

16 (a) Informant Mrs Dennis Sexton
(b) Address 4934 Pennington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Annapolis Blvd

18 (a) Funeral director John F Denny Inc
(b) Address 714 Light St.

19 (a) (Date rec'd by registrar) (b) [illegible]

JAN 23 1947

vs 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** January 20th 1947 at 9 1/4 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 18 1947 to Jan 20 1947, and that I last saw h[illegible] alive on Jan 26 1947.

| Immediate cause of death | Duration |
|---|---|
| Septicemia | 3 days |
| Due to Osteomyelitis Rt Knee Joint | 10 days |
| Due to Generalized skin infection & lower extremities (Contingent) | [illegible] |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carl Lubin M. D.
Address 320 Patapsco Ave Date signed 1/24/47

G17805 BIDDISON

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1310

Registered No. G17805

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2323 E Chase
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-4
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2323 Chase
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Harry Biddison

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-6140

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | divorced |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 17 1892

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 | 4 | 5 | hr. min. |

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation Bartender

11. Industry or business

FATHER
12. Name Geo H Biddison
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Tink
15. Birthplace Md

16 (a) Informant John Biddison
(b) Address 1117 N Eaton

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 24 47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Co Md

18 (a) Funeral director Welch Funeral Home
(b) Address 2008 Orleans

19 (a) JAN 23 1947 Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 21 1947 at 7p M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1947 to Jan 21 1947, and that I last saw h 17 alive on Jan 20 1947

| Immediate cause of death | Duration |
|---|---|
| decompensating cardio renal vascular disease | 3 mos. ? |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ford Schneider M. D.

Address 110 N Wheeler Ave Date signed 1-23-47

X

G47806

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G47806

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 23 Highland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 23 Highland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Clara May Thuman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Wm P Thuman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 2 1874

8. AGE: Years 72 | Months 2 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name Oliver Kidd
13. Birthplace Balto

MOTHER
14. Maiden Name Ella Johnson
15. Birthplace Balto

16 (a) Informant Harry F Thuman
(b) Address 1649 Argonne drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 25 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2116 Orleans St

19 (a) ... (Date rec'd by registrar) (b) ...

JAN 23 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1947, at 11 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1947 to Jan 21 1947 and that I last saw h. alive on Jan 21 1947

Immediate cause of death Acute Cardiac Failure — Duration

Due to Hypertension Cardio-Vascular disease

Due to Cardiac Decompensation

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E G Flanigan Jr

Address 3507 Fort ave Date signed M. D. 1-23-47

X

G17807

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 170c

G17807

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3307 Piedmont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Benjamin Berry Snyder

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 215-09-7759

| 4. Sex | 5. Color or race | 6 (a) Single, ~~married, widowed, or divorced.~~ |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 4 | 13 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Auditor

11. Industry or business C.M. Athey Paint Co.

FATHER
12. Name Benjamin Snyder
13. Birthplace Missouri

MOTHER
14. Maiden Name Mary A. Bellard
15. Birthplace Balto., Md.

16 (a) Informant Miss Emma A. Snyder
(b) Address 3307 Piedmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-24-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) (b) Washington Williams, M.D. Registrar

JAN 23 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 21 1947, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of Skull
Intracranial Hemorrhage
Intracerebral Hemorrhage

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 4/1
(a) Date of injury 1-16-47 at 12:30 A. M.
(b) Where did injury occur? Light & Redwood Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Pedestrian struck by auto

23. Signature Howard J. Mullis M.D.
Medical Examiner.
Date signed 1-22-47

X

G17808

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 124 B

G17808 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2400 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cecil Hood

3 (b) If veteran, name war

3 (c) Social Security Account No. 577-18-0171

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Rosia M. Hood

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19 1889

8. AGE: Years 57 | Months 6 | Days 2 | If less than one day hr. min.

9. Birthplace Unk.
(Town, county, and state)

10. Usual Occupation Foreign Representative

11. Industry or business Central West Coal Co.

FATHER
12. Name John G. Hood
13. Birthplace Md.

MOTHER
14. Maiden Name Maria MacCurdy
15. Birthplace Md.

16 (a) Informant Mrs. Rosia M. Hood.
(b) Address 2442 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location

18 (a) Funeral director Wm. J. Fickenscher & Son
(b) Address North & Green Sts.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 150 JAN 23 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-21 1947, at 3:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-19 1947, to 1-21 1947, and that I last saw him alive on 1-21 1947

Immediate cause of death Respiratory failure - tuberculosis. | Duration

Due to Fatal cutbons & ruptured esophageal varices

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Dorcas Clark M. D.
Address University Hospital Date signed 1-22-47

X

G17809 G12809

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH 121

Reg. Dist. No. .....

**1. PLACE OF DEATH:**
County 6723 ~~Dundalk~~ Railway Ave
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred: 26-
How long in hospital or institution? .....

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants, give residence of mother)
State Maryland County .....
City or town ~~Dundalk~~
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6723 Railaway ave
(If rural, give LOCATION)
2.(a) If veteran, name war .....

**3.(a) FULL NAME** Katherine Barutka

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Widow |

6.(b) Name of husband or wife John Barutka
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | | | ..... hrs. ..... min. |

9. Birthplace Poland (Town, county, and state)
10. Usual occupation Housework
11. Industry or business

FATHER
12. Name Anthony
13. Birthplace Poland

MOTHER
14. Maiden name Grabowska
15. Birthplace Poland

16. Informant Frank Lapka
Address 6723 Railway ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-24-47 (month) (day) (year)
Cemetery or crematory Sacred Heart of Mary
Location Baltimore County
18. Funeral director John M. Weber
Address 1401 S. Chester Street
19. JAN 23 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 1947 at 3:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 14 1947 to Jan. 21 1947
and that I last saw h.. alive on Jan 19 1947

| | DURATION |
|---|---|
| Immediate cause of death Peritonitis | 1 week |
| Due to Perforated Appendix | 1 week |
| Due to Acute Appendicitis | ? |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE Stephen C. Mackenzie M.D.
M. D. or other
Address 6714 Holabird Ave Date signed 1/21/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G17810

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 92 B

Registered No. G17810

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 11 E. Preston Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-2
(e) Length of stay in Baltimore (yrs., mos., or days) 68 Years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 E. Preston St.
(If rural give location)
(e) Citizen of foreign country? --- (Yes or No)
If yes, name country ---

3 (a) FULL NAME Georgia G. Hinds

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ---

6 (c) If alive, give age --years

7. Birth date of deceased (mo., day, yr.) --- 1879

8. AGE: Years 68 | Months --- | Days -- | If less than one day --hr. --min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business ---

FATHER
12. Name Edwin H. Hinds
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Gootee
15. Birthplace Maryland

16 (a) Informant Miss Maud Hinds
(b) Address 11 E. Preston Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meeks and Son
(b) Address 805 N. Calvert Street

19 (a) Jan 23 1947 Twillington Williams, M.D. Registrar

VS 130

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21 1947 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1946 to Jan 21 1947
and that I last saw h-- alive on Jan 21 1947

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Edema | |
| Due to Mitral endocarditis regurgitation | 6 mo |
| Due to ✓ | |
| Other Conditions ✓ | |

(Include pregnancy within 3 months of death)
Date of operation ✓
Major findings of operation: ✓
of autopsy: ✓

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? ✓ (Specify type of place)
(e) Means of injury ✓

23. Signature Chas F Blake M. D.
Address 202 Preston Date signed 1/23/47

X

G17811

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G17811

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3446 Leverton Ave
(c) Hospital or institution: 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town 3446 Leverton Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Augustus F Langley

3 (b) If veteran, name war —

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Theresa Langley

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Oct 6th 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 3 | 16 | hr. min. |

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business Carpenter

FATHER
12. Name Owen Langley
13. Birthplace Balto

MOTHER
14. Maiden Name Dont Know
15. Birthplace Balto

16 (a) Informant Theresa Langley
(b) Address 3446 Leverton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) Jan 25th

(c) Cemetery or crematory Oak Lawn Cem
Location Catty

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (Signature of local registrar) (b) Huntington Mitchell M.D.

JAN 23 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1947, at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1945 to Jan 22 1947 and that I last saw him alive on Jan 22 1947

| Immediate cause of death | Duration |
|---|---|
| (a) Uremia due to C.V. Disease | 1-45 |
| Acute Coronary Thrombosis | 6-12-46 |
| Due to (b) Congestive Failure | 12-2-46 |
| Due to | |
| Other Conditions Nil | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: Nil

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? Nil
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eastchurch M. D.

Address 1421 Fort Ave Date signed 1-23-47

X

# HEALTH DEPARTMENT—CITY OF BALTIMORE

G17812 G17812

## CERTIFICATE OF DEATH 42

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3205 Elgin Ave Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Fred A. Kuhn 15-7

If U. S. Veteran specify WAR

(a) Residence: No. 3205 Elgin Ave St., 16 [redacted] Baltimore Md

(Usual place of abode) (If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. Color or Race | 5. Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| M | W. | Married |

5a. If married, widowed, or divorced HUSBAND (or) WIFE Mary J. BRAUTIGAN

6. DATE OF BIRTH (month, day, year) 9/8/1881

| 7. AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 65 | 4 | 13 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Sales Mgr.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Mfgr.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (City or town) (State or country) U.S.A.

FATHER

13. NAME Frederick Kuhn

14. BIRTHPLACE (city or town) (State or country) Germany

MOTHER

15. MAIDEN NAME Hagenmund

16. BIRTHPLACE (city or town) (State or country) Canada

17. INFORMANT Mrs Fred A. Kuhn

(Address) 3205 Elgin Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Baltimore Date 1/25 1941

19. UNDERTAKER Philip J. Brautigan Sons

(Address) 1300 W. Baltimore St.

20. FILED 1/25 1941

Registrar.

JAN 23 1941 Huntington Williams, M.D.

### MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 1/21, 1941

22. I HEREBY CERTIFY, That I attended deceased from 10/27, 1941, to 1/21, 1941

I last saw him alive on 1/21 1941. Death is said to have occurred on the date stated above, at 7:24 p. m.

The principal cause of death and related causes of importance were as follows:

Amyotrophic lateral sclerosis. Duration Aug 1935

Other contributory causes of importance:

Was an operation performed? Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Robert A. Reiter M. D.

(Address) 3401 Windsor Ave.

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G17813

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G17813

Registered No. 1706

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 906 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** JAMES MILBURN

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Colored | married |

6 (b) Name of husband or wife Lillian
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 189?

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 10 | 8 | hr. min. |

9. Birthplace St. Mary's Co. Md.
(Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Thomas Milburn
13. Birthplace St. Mary's Co. Md.

MOTHER
14. Maiden Name Mary ? ? ?
15. Birthplace St. Mary's Co. Md.

16 (a) Informant Lillian M. Milburn
(b) Address 916 Harlem Ave.

17 (a) Burial (b) Date thereof Jan. 24 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or Crematory Balto. Nat'l Cem.
Location Baltimore, Md.

18 (a) Funeral Director George H. Hallam
(b) Address 163 Druid Hill Ave.

19 (Date received) JAN 23 1947 Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-20- 1947, at 12 10 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured pelvis
Intra-abdominal hemorrhage
Fractured left tibia and fibula
Fractured left femur

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: Burnell Hr.
(a) Date of injury 1-20-47 at 11 a. M.
(b) Where did injury occur? Westminster Pike, Md
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
Means of injury Passenger in auto collision, w/ truck

23. Signature George H. Merrill M.D.
Medical Examiner.
Date signed 1/20/47

VS 151

G17811 BCH B65303 BALTIMORE CITY HEALTH DEPARTMENT G17811

# CERTIFICATE OF DEATH ✓ 56 E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Lifelong + years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MARYLAND (b) County Baltimore
(c) City or town DUNDALK
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1718 MORNINGTON RD, APT B
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** KAREN LEE NORWOOD

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | WH | S |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 1 | 7 | hr. min. |

9. Birthplace BALTIMORE MARYLAND
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name JAMES EDWARD NORWOOD
13. Birthplace NEW YORK

MOTHER
14. Maiden Name MARION KATHERINE AHLERS
15. Birthplace NEW YORK

16 (a) Informant HOSPITAL RECORS
(b) Address

17 (a) Cremated (b) Date thereof 1/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Edgewood
Location Edgewood Rd Md

18 (a) Funeral director Wilson & Dye
(b) Address 1217 E Pratt St

19 JAN 23 1947 Huntington Williams M.D.
Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 22 1947, at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 21 Jan 1947, to 22 Jan 1947, and that I last saw h[illegible] alive on 22 Jan 1947

Immediate cause of death SHOCK — Duration

Due to operation
Excision of cystic hygroma

Due to neck

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 22 January 1947
Major findings of operation: cystic hygroma neck
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Evan B Chamberlin M. D.
Address Union Memorial Hosp Date signed 1/22/47

X

G17815 — BALTIMORE CITY HEALTH DEPARTMENT — G17815

Med Exam born. — CERTIFICATE OF DEATH 94a — Registered No.

Every item of information should be carefully supplied. The write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Ev... correct age is especially important. Physicians: please writ...

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr 10 min
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1717 E. Baltimore St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Nicola or Mario Bressi

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 49. | | | hr. min. |

9. Birthplace Italy (Town, county and state)
10. Usual Occupation Shoes Repairing
11. Industry or business

FATHER
12. Name Giuseppe Bressi
13. Birthplace Italy

MOTHER
14. Maiden Name Maria E. Ebbisposti
15. Birthplace Italy

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Frank Della Vecchia
(b) Address 52 N. Monroe St

19 (a) (Date rec'd by registrar) Huntington Williams, Asst

JAN 23 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 20 1947 at 11.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-20- 1947, to 1-20-1947 and that I last saw h[illegible] alive on 1-20-1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary Vascular Disease | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert C. Austrian
Address Johns Hopkins Hosp Date signed Jan 23 47

For J. R. Davis, by Howard E. Macklin, M.D.

G47816

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G47816

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Hotel Altamont Eutaw Place & Lanvale St.
(c) Hospital or institution: Baltimore, Maryland

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11

(e) Length of stay in Baltimore (yrs., mos., or days) 86 yrs. except while in Italy

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) ~~County~~ Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hotel Altamont Eutaw Place & Lanvale St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs. Emily O. Stone-Alcock

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Rev. George B. Stone-Alcock 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1860

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 86 | 10 | 28 | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

MOTHER / FATHER

12. Name William E. Alcock

13. Birthplace Baltimore, Maryland

14. Maiden Name Mary Grundy

15. Birthplace Baltimore, Maryland

16 (a) Informant Frank K Barnes

(b) Address 901 Maryland Trust Bldg

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 25 1947 (month) (day) (year)

(c) Cemetery or crematory Old St. Pauls

Location Balto Md

18 (a) Funeral director Henry McCulloch & Orchard St

(b) Address

19 (a) (Date rec'd by registrar) (b) Registrar

VS 18 JAN 23 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 22 1947 at 11.30 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 to Jan. 22 1947 and that I last saw h[illegible] alive on Jan 15 1947.

| Immediate cause of death | Duration |
|---|---|
| chronic myocarditis | 10 yrs |
| Due to arteriosclerosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Novak M. D.

Address 101 W. Read St Date signed 1-23-47

X

50841 C17817

BALTIMORE CITY HEALTH DEPARTMENT X

# CERTIFICATE OF DEATH √ 46 C

Registered No. C17817

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Govin
(If outside city or town limits, write RURAL and give town)
(d) Street No. 315 Blanch Field Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Millie A. Bradley.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Morley O. Bradley
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5-31-97

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 49 | 7 10 | 2 23 | hr. min. |

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Home duties
11. Industry or business

FATHER
12. Name Calvin Robinett
13. Birthplace Va

MOTHER
14. Maiden Name Mary Holbrook
15. Birthplace Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Jany 25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location "

18 (a) Funeral director John O. Mitchell & Son
(b) Address 1700 Eutaw Place

19 (a) (Date rec'd by registrar) (b)

JAN 23 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 23 1947 at 4:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 20 1947 to Jan. 23 1947 and that I last saw h.e.r. alive on Jan. 23 1947.

| Immediate cause of death | Duration |
|---|---|
| (a) Gastric hemorrhage | 24 hrs |
| Due to (b) Laceration | |
| Due to (c) Carcinoma of stomach with metastases | 3 mos |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Paul Higgins, M.D.
Address Johns Hopkins Hospital Date signed 23 Jan 1947

G17818

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 92E

G17818 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 940 Leadenhall
(c) Hospital or institution:
23-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs.) mos., or days) 20

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 940 Leadenhall St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Haley

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-01-3215

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1888

8. AGE: Years 58 | Months 10 | Days 6 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Lumberman

11. Industry or business

FATHER
12. Name William Haley
13. Birthplace N. C.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Molly Haney
(b) Address 940 Leadenhall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-24-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Balto City

18 (a) Funeral director Daniel L. Brown & Son
(b) Address 109 W Montgomery St

19 Filed JAN 23 1947 by [illegible]

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/21/1947, at 10 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 18 1947, to Jan 21 1947, and that I last saw him alive on Jan 20 1947

Immediate cause of death Endocarditis — Duration Influenza

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James C. Carper M. D.
Address 1146 S. Hanover St Date signed 1-22-47

VS 150

G17819

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

Registered No. G17819

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St. city
(c) Hospital or institution: Little Sisters of the Poor 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** Mary Hitchcock

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Charles Hitchcock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1866

8. AGE: Years 80 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Annie Arundel County Md
(Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER 12. Name James Thurrels
13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Anderson
15. Birthplace Maryland

16 (a) Informant Little Sisters of the Poor
(b) Address 920 Valley St. city

17 (a) Burial (b) Date thereof Jan 25 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Baltimore

18 (a) Funeral director Rita Weidefeld
(b) Address 900 E. Biddle St

19 (a) (b)

JAN 25 1947

VS 3

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Jan-22- 1947, at 7-35A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-10- 1947, to Jan 22- 1947, and that I last saw her alive on Jan 21- 1947.

| Immediate cause of death | Duration |
|---|---|
| Acute Dilatation of Heart- | 1 day. |
| Due to Chronic myocarditis | 5 yrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North av. Date signed 1/23/47

BC# G68080

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 122B

Registered No. [illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave
(c) Hospital or institution: The Church Home & Hospital 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da
(e) Length of stay in Baltimore (yrs., mos., or days) 5 da

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Mayld (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1865 Marshall Rd.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Fleshman, Baby Boy

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | S |

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 18 Jan 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 5 | hr. min. |

9. Birthplace Baltimore, Maryland.
(Town, county, and state)

10. Usual Occupation Baby.

11. Industry or business

FATHER
12. Name Ernest Fleshman
13. Birthplace West Virginia

MOTHER
14. Maiden Name Hazel Brammer
15. Birthplace Virginia

16 (a) Informant Father
(b) Address 1865 Marshall Road.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan 24/47 (month) (day) (year)
(c) Cemetery or crematory Lowell Valley
Location Rainelle W Va

18 (a) Funeral director Welsh Funeral Home
(b) Address 2002 Aliceanna St

19 JAN 23 1947 [illegible]

## MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Jan 1947, at 1. A M

21. I certify that death occurred on the date above stated; that I attended deceased from 18 Jan 1947 to 23 Jan 1947, and that I last saw h... alive on 23 Jan 1947.

| Immediate cause of death | Duration |
|---|---|
| Peritonitis | |
| Fracture. | |
| Due to acute lobar pneumonia | |
| Due to intestinal obstruction adhesions large bowel. | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation 19 Jan 1947

Major findings of operation: adhesions large bowel & perforation

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nicholas J. Fohlerman M. D.
Address The Church Home & Hosp. Date signed 23 Jan 47

VS 150

X

G47821

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

567

G47821 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Harford
(c) City or town Aberdeen (If outside city or town limits, write RURAL and give town)
(d) Street No. 67 Swan St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** George R. Odt.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife Emma M. Odt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23-1902

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 44 | 8 9 | | hr. min. |

9. Birthplace Union Co. Pa. (Town, county, and state)
10. Usual Occupation Sheet Metal Worker
11. Industry or business

MOTHER FATHER
12. Name George M. Odt
13. Birthplace Sunbury Pa.
14. Maiden Name Jennie Bubb
15. Birthplace Pa.

16 (a) Informant Emma M. Odt.
(b) Address 67 Swan St. Aberdeen

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan. 23 47 (month) (day) (year)
(c) Cemetery or crematory
Location Sunbury Pa.

18 (a) Funeral director John Fleming Son
(b) Address Aberdeen, Md.

19 JAN 23 1947 (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/23 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/22 1947 to 1/23 1947, and that I last saw him alive on 1/23 1947.

Immediate cause of death Cardio respiratory failure — Duration

Due to 3rd Ventricular Tumor

Due to Cerebellar pressure cone

Other Conditions Medullary failure

(Include pregnancy within 3 months of death)

Date of operation 1/22/47

Major findings of operation: 3rd. Ventricular Tumor

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Rosenberg M.D.
Address Aberdeen, Md. Date signed 1/23

VS 150

G27822 BCH G61456 50 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH ✓ X 120 G27822 Registered No.

PLEASE WRITE PLAINLY. WITH UNPADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Green,
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Howard
(c) City or town Ellicott City (If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D. #1 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Donaldson

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| None | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife None
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 10, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 2 | 13 | hr. min. |

9. Birthplace Elkton (Town, county, and state)
10. Usual Occupation Newborn
11. Industry or business

FATHER
12. Name Andrew J. Donaldson
13. Birthplace Mt. Airy Md

MOTHER
14. Maiden Name Mamie Wehland
15. Birthplace Ellicott City Md

16 (a) Informant Andrew J. Donaldson
(b) Address Ellicott City Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 25/47 (month) (day) (year)
(c) Cemetery or crematory St. Johns
Location Ellicott City Md.

18 (a) Funeral director Easton Dora
(b) Address Ellicott City Md.

JAN 23 1947 (Date rec'd by registrar)

(b) Hunter Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-23 1947; at 8:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22 1947 to 1-23 1947, and that I last saw him alive on 1-23 1947

| Duration |
|---|
| |

Immediate cause of death Pneumonia
Due to Fatal
Due to cerebral edema
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy cerebral edema

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. B. Harley, M.D.
Address Univ. Hosp. Date signed 1-23-47

M. D.

VS 150

D47823.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

49a

Registered No. D47823

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address Calhoun & Fayette St.

(c) Hospital or institution Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13da.

(e) Length of stay in Baltimore (yrs., mos., or days) —

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md. (b) County Carroll

(c) City or town ~~(Westminster)~~ Gist

(If outside city or town limits, write RURAL and give town)

(d) Street No. —

(If rural give location)

(e) Citizen of foreign country? X (Yes or No)

If yes, name country

**3 (a) FULL NAME** Nellie Kopp

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-42-5617

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | S |

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-4-02

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 44 | 2 | 17 | hr. min. |

9. Birthplace Baltimore Md

(Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER: 12. Name Chas. Kopp

13. Birthplace Maryland

MOTHER: 14. Maiden Name Laura (Sadie) Gaylon Jordan

15. Birthplace Maryland

16 (a) Informant Nellie Kopp

(b) Address ~~Westminster~~ Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-24-47 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Mt. Pleasant

Location Hampstead, Carroll Co. Md.

18 (a) Funeral director C. M. Watts

(b) Address Winfield Md

19 (a) Filed 1-24-1947 (b) Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-21 1947, at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-7 1947, to 1-21 1947, and that I last saw her alive on 1-21- 1947

| Immediate cause of death | Duration |
|---|---|
| Intestinal Stasis | 1 Mo? |
| Due to Carcinomatosis | 3 Mo? |
| Due to ? Primary Ca Ovary | 11 Mo? |
| Other Conditions — | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Stanley B. Klyanowe M. D.

Address Franklin Square Hosp Date signed 1-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G47824 G47824

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V1826

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 1616 McKeane Avenue

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 McKeane Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Alice PEREGORY

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Robert Peregory
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23rd 1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 3 | 29 | hr. min. |

9. Birthplace D.J.m. Balto Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Maria Stiffler
15. Birthplace Md.

16 (a) Informant Edna Bridges
(b) Address 1616 McKean Ave

17 (a) Burial (b) Date thereof 1/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mountland Park
Location Parkville Md

18 (a) Funeral director William Cook Inc.
(b) Address 217 St. Paul St.

19 (a) 1/24/47 (b)
(Date rec'd by registrar) Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 2nd 1947, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Mechanical suffocation

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-22-47 at Between 2:15 & 5 P.M. 15/2
(b) Where did injury occur? 1616 McKeane Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Head pushed into boiling water

23. Signature George F. Merrell M.D.
Medical Examiner.
Date signed 1/23/47

G47825

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 1477 G47825

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 954 Homestead St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 954 Homestead St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Hugh B Anderson

3 (b) If veteran, name war: no
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Florence A
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): Jan 8 1868

8. AGE: Years 67 | Months 0 | Days 13 | If less than one day hr. min.

9. Birthplace: Jessup Md (town, county, and state)

10. Usual Occupation: Electrician
11. Industry or business:

FATHER
12. Name: Edward T Anderson
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Elizabeth Gardner
15. Birthplace: Jessup Md

16 (a) Informant: Mrs Hugh Anderson
(b) Address: 2528 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/47 (month) (day) (year)
(c) Cemetery or crematory: Mt Olivet
Location: Baltimore Md

18 (a) Funeral director: Tilburn & Son
(b) Address: 1217 E Fort Ave

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan 23 1947, at 10:37 M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 15 Nov. 1947 to 23 Jan. 1947, and that I last saw him alive on 22 Jan 1947.

| | Duration |
|---|---|
| Immediate cause of death: Broncho-pneumonia | 3 Days |
| Due to: Carcinoma of Left Lung | 5 mo. |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Lloyd E. Saylor M. D.
Address 3902 Greenmount Ave Date signed 23 Jan 47

VS 150

G47826

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 39B

Registered No. G47826

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert St
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 619 N. Calvert St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Everett H. Anderson

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-07-3326

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ella Anderson
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 15, 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 0 | 8 | hr. min. |

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Machine Operator
11. Industry or business E. Z. Stitcher Co.

FATHER
12. Name Roderick Anderson
13. Birthplace Maryland

MOTHER
14. Maiden Name Eliza Miles
15. Birthplace Maryland

16 (a) Informant Wife
(b) Address 619 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/47 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glenburnie, Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

JAN 24 1947 Huntington Williams, MD

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-23 1947 at 2:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1947 to 1-23 1947 and that I last saw him alive on 1-23 1947

| Immediate cause of death | Duration |
|---|---|
| Typhoid | |
| Due to Encephalitis | |
| Due to | |
| Other Conditions Possible Pneumonia | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurence J. Kent M. D.
Address Mercy Hospital Date signed 1-27-47

X

G47827 BC# G67342

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 157E

Registered No. G47827

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town Turner Station (If outside city or town limits, write RURAL and give town)
(d) Street No. 108 Chestnut Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Jackson

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Black | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 9, 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 10 | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Jackson
13. Birthplace ? Md.

MOTHER
14. Maiden Name Pernetta Boyd
15. Birthplace South Carolina

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo JAN 24 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 24 1947 (Date rec'd by registrar) [illegible] Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 19 1947, at 1:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9 1947 to Jan 19 1947, and that I last saw h or alive on Jan 19 1947

Immediate cause of death — Duration

Congenital heart disease
? congenital anomalies multiple
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Russell Jordan M. D.
Address Johns Hopkins Hospital Date signed 1-20-47

VS 150

X

G47828
a 52604

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

159

G47828
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Harford
(c) City or town Edgewood Arsenal (If outside city or town limits, write RURAL and give town)
(d) Street No. 211 A. Lower South (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Baby Boy Jankowicz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1 15 47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 4 | hr. min. |

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Lt. Bruno J. Jankowicz
13. Birthplace N.Y.

MOTHER
14. Maiden Name Sarah Lisa Hannah
15. Birthplace Texas

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo JAN 24 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 24 1947 (Signature of City Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan - 19 - 1947 at 12:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15- 1947 to 1-19- 1947 and that I last saw him alive on 1-19- 1947

Immediate cause of death: Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip P Bruce M.D.
Address Johns Hopkins Hosp Date signed 1-19-47

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47829

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G47829

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnet Ave.
(c) Hospital or institution:
Pine Ridge Nursing Home 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town 1820 Chilton St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** SAMUEL A. WELSHOFFER

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widower |

6 (b) Name of husband or wife Nellie Welshoffer
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 18, 1858

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 88 | 5 | 4 | hr. min. |

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Maintenance Dept. (retired)
11. Industry or business P. R. R.

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Daniel Casey
(b) Address 1820 Chilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/24/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 15 JAN 24 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 22, 1947 at 6:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 15 1947 to 1/22 1947 and that I last saw him alive on 1/22 1947

Immediate cause of death Cardio Vascular Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. Dee Parker M. D.
Address 4703 Hampnet Rd Date signed 1/23 1947

Birth Certificate
G47830
4-69327

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

160 C

Registered No. G47830

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 min.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balt
(c) City or town Balt.
(If outside city or town, limits write RURAL and give town)
(d) Street No. 4605 Hartford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Girl Panusha

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | S |

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-23-47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 3 min. | | | hr. 3 min. |

9. Birthplace Baltimore Baltimore, Md.
(Town, county, and state)

10. Usual Occupation INFANT

11. Industry or business

FATHER
12. Name Mr. William Panusha
13. Birthplace Balt.

MOTHER
14. Maiden Name Mrs. Mary M Panusha
15. Birthplace Balt.

16 (a) Informant Mrs. Mary M Panusha
(b) Address 4505 Hartford Rd-Balto

17 (a) Buried (b) Date thereof 1-24-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Dunbarton
Location Balto Md

18 (a) Funeral director Frank Grocholski
(b) Address 900 S. Chester St

19 (a) (Date rec'd by registrar) (b) Wm. [illegible] M.D. Registrar

VS Form 1 JAN 24 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23 1947, at 12:42 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/22 1947 to 1/23 1947.
and that I last saw her alive on 1/23 1947.

Immediate cause of death Asphyxia — Duration
Fluida
Due to Abruptio Placentae
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 1/22-23/47
Major findings of operation: Abruptio Placentae. Fetus in distress
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. P. Brunkenhoefer M.D.
Address Mercy Hosp Date signed 1/23/47

G47831

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

46 B

G47831

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Balto Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6912-5th Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** August Gorray

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-07-9916

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | |

6 (b) Name of husband or wife Margarete Gorray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23-1895

| 8. AGE: Years | Months | Days | If less than one day: hr. | min. |
|---|---|---|---|---|
| 51 | 4 | 29 | | |

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Blacksmith
11. Industry or business

FATHER
12. Name Gottlieb Gorray
13. Birthplace Germany

MOTHER
14. Maiden Name Justine (?)
15. Birthplace Germany

16 (a) Informant Mrs. Margarete Gorray
(b) Address 6912 Fifth Ave. Dundalk Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 25-47 (month) (day) (year)
(c) Cemetery or crematory Trinity Lutheran Cem
Location Joppa - Md.

18 (a) Funeral director Charles J. Schwab
(b) Address 3512 Frederick Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams

VS JAN 24 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-21 1947, at 2.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-13 1947 to 1-21 1947, and that I last saw him alive on 1-21 1947.

Immediate cause of death Respiratory failure — Duration

Due to Hemothorax, L

Due to Carcinomatosis — Gastric Ca. c. metastasis to

Other Conditions Dec'd Surg.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. E. Hallenberg M.D.
University Hospital
Date signed 1-21-47

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

51B G47832

Registered No.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4505 Arabia Ave St. 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 5 yrs. 2 mos. da. How long in U. S. If of foreign birth 73 yrs. mos. ds.

2. FULL NAME James Walter Bayley

If U.S. Veteran specify WAR

(a) Residence No. 4505 Arabia Ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. Color or Race | 5. Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| M | W. | Married |

5a. If married, widowed, or divorced (or) WIFE of Maude Otma Bayley

6. DATE OF BIRTH (month, day, year) Dec. 7, 1873

| 7. AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| 73 | | 1 | 15 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Minister

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Methodist Church

10. Date deceased last worked at this occupation (month and year) June 1946

11. Total time (years) spent in this occupation 27

12. BIRTHPLACE (city or town) (State or country) Howard Co. Md. (Cherry Grove)

FATHER

13. NAME Joshua Warfield Bayley

14. BIRTHPLACE (city or town) (State or country) Howard Co, Md. (Cherry Grove)

MOTHER

15. MAIDEN NAME Ella Hood

16. BIRTHPLACE (city or town) (State or country) Howard Co Md.

17. INFORMANT Maude Otma Bayley

(Address) 4505 Arabia Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Florence Md Date 1-25 1947

19. UNDERTAKER F.C. Heginbothom

(Address) Ellicott City Md

20. FILED JAN 24 1947 Registrar.

Waiting for Williams

### MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Jan 22, 1947

22. I HEREBY CERTIFY, That I attended deceased from October, 19 46 to Jan 22, 1947

I last saw him alive on 1/22/47, 19 . Death is said to have occurred on the date stated above, at 3:50 P. m.

The principal cause of death and related causes of importance were as follows:

Cause of last illness: Cerebral Thrombosis

Pneumonia

Other contributory causes of importance:

Was an operation performed? Yes Date of Sept 6, 1946

For what disease or injury? Ca of prostate

What test confirmed diagnosis? Biopsy Was there an autopsy? No

23. If death was due to external cause (violence) fill in also the following:

Accident, suicide, or homicide? — Date of injury 19

Where did injury occur? —
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No. If so, specify

(Signed) Walter E. Kaylor M. D.

(Address) 4531 Harford Rd.

Kaylor

Information should be entered EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G47833

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 1937

G47833 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1402 N. Montford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Raymond Stoll

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Elizabeth C. Stoll
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) July 29 1898

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 48 | 5 | 26 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation President
11. Industry or business Northeastern Bldg & Loan Assn.
FATHER 12. Name John M. Stoll
13. Birthplace Balto. Md.
MOTHER 14. Maiden Name Louise Menzel
15. Birthplace Balto. Md.
16 (a) Informant Elizabeth C. Stoll
(b) Address 1402 N Montford Ave
17 (a) Burial (b) Date thereof 1-25-37
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cem.
Location
18 (a) Funeral director John C. Milley Inc
(b) Address 2435 E Oliver St
19 (a) Received (b) Registrar
JAN 24 1937 Washington Williams M.D. Registrar

VS 181

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/22 1937 at 9:40 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to h-t death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hypertensive CV disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature R. F. Gutowski M.D.
Medical Examiner.
Date signed 1/23/37

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47834

BALTIMORE CITY HEALTH DEPARTMENT X

# CERTIFICATE OF DEATH √ 61

Registered No. G47834

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Williams & Caton Aves.
(c) Hospital or institution St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 103 Locust Drive (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elias Aaron Baugher

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-1-1889

8. AGE: Years 57 | Months 8 | Days 22 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation President

11. Industry or business C.A. Blackshere Co.

FATHER 12. Name Jacob N. Baugher

13. Birthplace Pa.

MOTHER 14. Maiden Name Byremina Dennis

15. Birthplace Pa.

16 (a) Informant Alice B. Simmons

(b) Address 103 Locust Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jany 25/47 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville Md

18 (a) Funeral director John D. Mitchell Sons

(b) Address 1600 Eutaw Place

19 (a) (Date rec'd) JAN 24 (b) 1947 Lexington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 23 1947, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 1947 to 1-23 1947 and that I last saw h alive on 1-23 1947.

Immediate cause of death Coma — Pleurisy
Antecedent — Myocarditis
Due to Cirrhosis
Due to Diabetes Mellitus

| | Duration |
|---|---|
| | |
| | |
| | |
| | |
| | |

Other Conditions Lumbar adenitis
Genito-fecal anus Pneumonia N.J. Mc
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard L. Mitchell, M.D.
Address Hayne Date signed 1/23/47

VS 150

Lexington Williams, M.D.
Howard L. Mitchell, M.D.

G47835

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G47835 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 610 Madeira ST
(c) Hospital or institution: 7

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)
(d) Street No. 610 Madeira (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SANTIA SADIE HENSON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | C. | Widow |

6 (b) Name of husband or wife SAMPEL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/25/74

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 4 | 27 | hr. min. |

9. Birthplace Dorchester, County, Md. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name ANTHONY BARKLEY
13. Birthplace Md.

MOTHER
14. Maiden Name MARIA ?
15. Birthplace Md.

16 (a) Informant ERNEST THOMPSON
(b) Address 610 Madeira St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1/25/47 (month) (day) (year)
(c) Cemetery or crematory LAUREL
Location BALTO., Md

18 (a) Funeral director Joseph T. Corkran
(b) Address 1, 504 N. Central Ave

19 (a) JAN 24 1947 Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH JAN. 21 1947, at 4 40 F M

21. I certify that death occurred on the date above stated; that I attended deceased from September 1946 to January 1947 and that I last saw h[illegible] alive on January 25th 1947

Immediate cause of death Coronary Thrombosis — Duration unknown

Due to Arteriosclerosis

Due to Hypertension

Other conditions Pulmonary Tuberculosis, Postoperative Hernioplasty (Includes pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Davidson M. D.
Address 1623 E. N. Ave Date signed 1-25-47

VS 150

G47836

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47836 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2901 Rueckert Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2915 Strathmore Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Margaret H. Schardt

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-23-1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 11 | 0 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Michael Schardt
13. Birthplace Germany

MOTHER 14. Maiden Name Henrietta ?
15. Birthplace Germany

16 (a) Informant Mrs. Etta Minnick
(b) Address 2901 Rueckert Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-25-47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto. Co., Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) (b)
JAN 24 1947 Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 23 1947, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1943, to Jan 23 1947 and that I last saw h[illegible] alive on Jan 21 1947.

Immediate cause of death: Chronic Myocarditis — Duration 4 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: none
of autopsy: no

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury none

23. Signature L. L. Eordy M.D.
Address 5106 Harford Rd. Date signed 1-23-47

VS 150

G47837

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47837 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Union + Caroline
(c) Hospital or institution: St. Joseph. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 416 Glenarm, Md. Glen Arm (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

**3 (a) FULL NAME** HARVEY CLARKE Sr.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Gertrude V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/28/79

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 6 | 25 | hr. min. |

9. Birthplace Anne Arundel Co.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Grocery

FATHER
12. Name Samuel Clarke
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Hands
15. Birthplace Md.

16 (a) Informant Mr. Harvey Clark Jr.
(b) Address 3552 Chesterfield

17 (a) Burial (b) Date thereof 1-27-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 530 S. Mansfield Ave.

19 (a) JAN 24 (b) 1947
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/23/47, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 1947 to 1/23 1947, and that I last saw h[illegible] alive on 1/23 1947

| Immediate cause of death | Duration |
|---|---|
| Cardio-respiratory failure | |
| Due to Auricular fibrillation | |
| Due to Hypertension Cardio-vascular disease | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Dilated Cardiac Passive Hyperemia

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Richard H. Young M. D.
Address St. Joseph Hosp. Date signed 1/23/47

VS 150

Huntington Hill

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47838

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

106B

Registered No. G47838

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 703 Tessier St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 703 Tessier St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** THEODORE M. MILLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Married |

6 (b) Name of husband or wife Laura Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 9 10 | | hr. min. |

9. Birthplace South Carolina
(Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name Charles E. Miller
13. Birthplace S. C.

MOTHER
14. Maiden Name Sarah LaGee
15. Birthplace S. C.

16 (a) Informant Mrs. Laura Miller
(b) Address 703 Tessier St.

17 (a) Burial (b) Date thereof 1-26-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (b)
(Date rec'd by registrar)

Huntington Williams, M.D.

VS JAN 24 1947

**MEDICAL CERTIFICATION**

P

20. DATE OF DEATH January 22 1947, at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24 1946 to Jan 22 1947 and that I last saw h.im alive on Jan 21 1947.

| Immediate cause of death | Duration |
|---|---|
| (a) Cerebral Thrombosis | 3 mos |
| Due to | |
| Due to | |
| Other Conditions Hypertension. | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Douglas Sheppard M. D.
Address 404 Dulaney Date signed 1/24/47

G47839 G47839

BALTIMORE CITY HEALTH DEPARTMENT

AB-106399 **CERTIFICATE OF DEATH** 58B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mos-26days
(e) Length of stay in Baltimore (yrs., mos., or days) 17yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 Saratoga St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Talley

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | Married |

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29- 1923

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 23 | 4 | 23 | hr. min. |

9. Birthplace N.J.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Rufus Strickland
13. Birthplace N.C.

MOTHER
14. Maiden Name Cleo Jones
15. Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Jan. 26, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington Mem.
Location

18 (a) Funeral director Mrs. Katie P. Williams
(b) Address 322 N. Schroeder St.

19 (a) Date received JAN 24 1947 (b) by Clayton Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 22- 19 47, at 8.45A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-26 19 46, to 1-22 19 47, and that I last saw her alive on 1-22 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure | |
| Due to Polysarositis and vegetative endocarditis | |
| Due to unknown cause | over |
| Other Conditions Obesity | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin C. Evans, M. D.
Address Balto. City Hospitals Date signed Jan. 23, 47

X

G47840

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 171a

G47840 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 909 N. Stricker St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Susie Roman

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Colored | Married |

6 (b) Name of husband or wife Frank Roman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 29, 1901

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 45 | 10 | 21 | hr. min. |

9. Birthplace Blackstock S. C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John F. Hall
13. Birthplace Blackstock S. C.

MOTHER
14. Maiden Name Julia Ann Dixon
15. Birthplace Blackstock S. C.

16 (a) Informant Fred. Hall
(b) Address 909 N. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 20, 1947 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 3229 W. Lafayette Ave.

JAN 24 1947 (Signature of registrar) Katie R. Williams Reg. M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 20th 1947, at 6.45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Transverse Myelitis, traumatic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-11-47 at 6 P.M.
(b) Where did injury occur? Inside, street car
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fell out of St. Car 26 street car
23. Signature Howard J. Madeira M.D. Medical Examiner.
Date signed 1-21-47 location unk.

VS 191

G47841

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 122

G47841
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 841 W. Lexington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 841 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Spencer Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 7 | 5 | hr. min. |

9. Birthplace Chestertown Md.
(town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Harry Smith
13. Birthplace Chestertown Md.

MOTHER
14. Maiden Name Rebecca
15. Birthplace Rock Hall Md.

16 (a) Informant Pero Akens
(b) Address 841 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 25, 1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Wm. Kate & Williams
(b) Address 822 W. Baltimore St.

JAN 24 1947 (a) (Date received by registrar) (b) Registrar

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1947 at 5:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1947 to Jan 21 1947 and that I last saw him alive on Jan 20 1947

Immediate cause of death Nephritis

| | Duration |
|---|---|
| | 2 |
| Due to | 10 days |
| | No Entry |
| Due to | |
| | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1321 Fountain Ave Date signed Jan 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DONAL

C47842 BALTIMORE CITY HEALTH DEPARTMENT C47842

CERTIFICATE OF DEATH 170c Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 15-
(c) Hospital or institution: West Balto. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 Cedardale Road (Rural Route location) 3700 Edgedale Rd
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald C. Heinz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife Single

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1930

8. AGE: Years 16 | Months 8 | Days 5 | If less than one day hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Scholarly

11. Industry or business

FATHER 12. Name C. Frederick Heinz
13. Birthplace Md.

MOTHER 14. Maiden Name Thelma A. Hazard
15. Birthplace Md.

16 (a) Informant Family
(b) Address 3700 Edgedale Rd.

17 (a) (Burial, cremation, or removal) B. (b) Date thereof 1-25-47 (month) (day) (year)
(c) Cemetery or crematory London Pk.
Location Frederick, Md.

18 (a) Funeral director Jones & McCurley
(b) Address 130 S. Fort Ave.

19 JAN 24 1947 (b) (Signature of Registrar) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 22, 1947 at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fract. skull, multiple fractures

Due to

Other Conditions Lacerations, bruises, abrasions and shock
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-22-47 at 4:15 P.M. 15/11
(b) Where did injury occur 3700 Edgewood Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? NO
(d) Means of injury Motor scooter and truck

23. Signature Howard J. Madden Coroner M.D.
Medical Examiner.
Date signed 1-23-47

VS 191

X

G47843

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G47843

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 6506 Fait, Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6506 Fait, Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARY S. ASHBURN

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife James Ashburn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 23, 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 0 | 29 | hr. min. |

9. Birthplace W.Va.
(Town, county, and state)
10. Usual Occupation House-wife
11. Industry or business Home

FATHER
12. Name L. D. Russell
13. Birthplace Pa.

MOTHER
14. Maiden Name Florinda A Tap
15. Birthplace W.Va.

16 (a) Informant James Ashburn
(b) Address 6506 Fait, Ave.

17 (a) Burial (b) Date thereof 1 24 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location German Hill Rd.

18 (a) Funeral director Lilly & Euler Inc.
(b) Address 403 S. Wolfe, St. Balto.

19 JAN 24 1947 (b) Huntington Williams M.D.
Received by Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 21 1947 at 11P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Jan 21 1947 and that I last saw her alive on 1/20 1947

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia | 2 days |
| Due to Myocarditis, chronic | 5 yrs |
| Due to Arteriosclerosis, generalized | 10 yrs |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David H. Andrews M.D.
Address 2 Kingsley Rd Date signed 1/24/47
Glendale Md

V S 150

G47844

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Register G47844

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 228 East St
(c) Hospital or institution: 51
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 228 East St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joyce Wynn

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Col | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan-29-1929

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 17 | 11 | 21 | 5 hr. min. |

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Willie Jordan
13. Birthplace Va

MOTHER
14. Maiden Name Reba Whittney
15. Birthplace Va

16 (a) Informant Reba Jordan
(b) Address 228 East St

17 (a) Burial (b) Date thereof 1-24-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A A Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) JAN 24 1947 Registrar Williams

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23 1947, at 2:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-4 1947 to 1-23 1947 and that I last saw her alive on 1-23 1947.

| | Duration |
|---|---|
| Immediate cause of death: Pneumonia | 10 Days |
| Due to: Tuberculosis | 3 mo. |
| Due to: | |
| Other Conditions: | over |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. W. McDaniel M. D.
Address 807 N. Caroline Date signed 1-24-47

X

G47845

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 52B

G47845 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 325 N Streeter St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto — (If outside city or town limits, write RURAL and give town)
(d) Street No. 325 N Streeter St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** George H. Little

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | M |

6 (b) Name of husband or wife Sarah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/25/1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 9 | 29 | hr. min. |

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Unc.
11. Industry or business

FATHER
12. Name Aaron Little
13. Birthplace Md

MOTHER
14. Maiden Name Linthicum
15. Birthplace Md

16 (a) Informant Sarah Little
(b) Address 325 N. Streeter St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/26/47 (month) (day) (year)
(c) Cemetery or crematory Puncheon Run Md
Location Md

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Pennsman St

19 JAN 24 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** January 22 1947, at 11:25 P M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Carcinoma of Urinary Bladder

Due to

Other Conditions Arteriosclerotic Cardio-Vascular disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William L. Hedrick M.D. Medical Examiner.
Date signed Jan 23, 47

G47846

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47846 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1116 Weldon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Samuel Forbes

3 (b) If veteran, name war
3 (c) Social Security Account No. 212-18-8098

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Marjorie Forbes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14 - 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 2 | 9 | hr. min. |

9. Birthplace Scotland (Town, county, and state)
10. Usual Occupation Machinist Helper
11. Industry or business

FATHER 12. Name James Forbes
13. Birthplace Scotland
MOTHER 14. Maiden Name Mitchell
15. Birthplace Scotland

16 (a) Informant Mrs. Marjorie Forbes
(b) Address 1116 Weldon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 25 47 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

JAN 24 1947 (Date rec'd by registrar) (b) Hampton Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 23, 1947 at [illegible] AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19 1947, to Jan. 23, 1947, and that I last saw him alive on Jan 23, 1947.

Immediate cause of death Tuberculosis

Due to Generalized peritonitis

Due to Perforated peptic ulcer

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Tentative; Perforated peptic ulcer

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter S. Couch M. D.
Address University Hosp. Date signed Jan 23, 47

VS 150

G47847

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47847

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 413 East Federal Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 413 E. Federal Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Frank Randall

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Colored | Married |

6 (b) Name of husband or wife Della Randall

6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) March 1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 54 | 10 | | hr. min. |

9. Birthplace Surry Co. Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Alonza Randall
13. Birthplace Va.

MOTHER 14. Maiden Name Martha Johnson
15. Birthplace Va.

16 (a) Informant Della Randall
(b) Address 413 E. Federal St

17 (a) Burial (b) Date thereof 1-24-1937
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location D. A. C. Md.

18 (a) Funeral director Barron Francis W. Wright
(b) Address 711 Aisquith St

19 (a) JAN 24 1937 (b) Huntingtown, Md.
(Date rec'd by registrar)

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 21, 1937 at 12 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic heart disease
Cerebral edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public bldg.? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 1/22/37

G47848 BC# D65024

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH ✓161a

G47848 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: President Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 Division St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby f Viola Marvin

3 (b) If veteran, name war / 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | Negro | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 4 | hr. min. |

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Fred Marvin
13. Birthplace Burmingham ala.

MOTHER 14. Maiden Name Viola Griffin
15. Birthplace Lewisburg Va.

16 (a) Informant Viola Marvin
(b) Address 1706 Division St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

JAN 24 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec 16, 1946, at 12 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12, 1946, to Dec 16 1946, and that I last saw him alive on Dec 16, 1946.

| Immediate cause of death | Duration |
|---|---|
| Congenital Atelectasis | |
| Due to Eclampsia (mother) | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm E. L. Camper M. D.
Address 636 W. Lexington Date signed 12-13-46

VS 150 Kept for anatomical purposes +

G47849 CWK-107128 BC# G66363

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

159

Registered No. G47849

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 Days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Argyle Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy Johnson-Lorraine

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27-1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 16 17 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Herbert Johnson
13. Birthplace Maryland

MOTHER
14. Maiden Name Lorraine Finney
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Cremated (b) Date thereof 1-20-47
~~Burial~~, cremation, ~~removal~~ (month) (day) (year)
(c) ~~Cemetery~~ crematory Baltimore City Hospitals
Location 4940 Eastern Ave ( Records )

18 (a) Funeral director
(b) Address

19 (a) JAN 24 1947 Huntington, W. Va. Registrar

## MEDICAL CERTIFICATION

P

20. DATE OF DEATH January 13x 19 47 at 12:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 27 19 46 to Jan. 13 19 47 and that I last saw him alive on Jan. 13 19 47

| Immediate cause of death | Duration |
|---|---|
| Prematurity | Life |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes M. D.
Address Balto City Hosp Date signed Jan. 16 '47

V S 150

G47850 BG# G63624

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

Register No. G47850

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Lombard + Greene
(c) Hospital or institution: University Hospital 18
(d) Length of stay in hospital or institution (yrs., mos., or days) 63 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos - 3 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 816 Hollins St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Jeremiah Thomas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/20/46

8. AGE: Years | Months 2 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Frank Thomas

13. Birthplace Pennsylvania

14. Maiden Name Lena Fenner

15. Birthplace

16 (a) Informant Mr. Frank B. Thomas

(b) Address 816 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 24 '47 (month) (day) (year)

(c) Cemetery or crematory

Location Longmont, Pa.

18 (a) Funeral director Henry H. Wighe

(b) Address 4101 Edmondson Ave

19 (a) JAN 24 1947 (b) Huntington Williams M.D.

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** June 23, 1947, at 6 PM

**21.** I certify that death occurred on the date above stated; that I attended deceased from 11/25/1946, to 1/23/1947, and that I last saw h[illegible] alive on 1/23/1947.

Immediate cause of death: Respiratory Failure — Duration: 2 mos 3 days

Due to: Prematurity

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Slight ischemia brain

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. W. Hall

Address University Hosp Date signed 1/24/47 (M. D.)

VS 150

Balt. Ind. X

G47851

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 148a

Registered No. G47851

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County.....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 529 N. Wolfe St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

**3 (a) FULL NAME** Amanda Savage 365732

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | single |

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec, 1925

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 21 | 1 | | hr. min. |

9. Birthplace Edgecomb Co., N.C.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business —

FATHER
12. Name Lawrence Savage
13. Birthplace N.C.

MOTHER
14. Maiden Name Mary R. Howard
15. Birthplace N.C.

16 (a) Informant Moses Howard
(b) Address 634 Howard St

17 (a) Removal (b) Date thereof 1-24-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rocky Mount
Location N.C.

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 104 N Montgomery St

19 (a) [illegible] (b) Huntington Williams, M.D.
Registrar

JAN 24 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/22 1947, at 7:05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Post Partum Eclamptic Toxemia

Due to.....

over

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature C. J. Lubinski M.D.
Medical Examiner.
Date signed 1-23-47

X

G47852

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 92 C

Registered No. G47852

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3723 Northern Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3723 Northern Pkwy.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SUSANNA SPIELMANN

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Herman Bernard

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 19, 1866

8. AGE: Years: 80 | Months: 7 | Days: 4 | If less than one day: hr. min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: George Kraft
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Mrs. Harry J. Brockman
(b) Address: 3723 Northern Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/47 (month) (day) (year)
(c) Cemetery or crematory PARKWOOD
Location Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (Date received by registrar) JAN 24 1947 Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/23 1947, at 2:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1945 to 1/23 1947 and that I last saw her alive on 1/23 1947

| Immediate cause of death | Duration |
|---|---|
| Chronic endocarditis (Rheumatic) | 20 yrs. |
| Due to | |
| Due to | |
| Other Conditions Arteriosclerosis Senility | 10 yrs. |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M.D.
Address 632 Belair Rd Date signed 1/23/47

VS 150

G47853

# HEALTH DEPARTMENT—CITY OF BALTIMORE G47853

## CERTIFICATE OF DEATH 937

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3917 Gwynn Oak Ave St. ..... Ward)

Registered No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ... da. How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

2. FULL NAME EMMA BOWEN 78

If U.S. Veteran specify WAR .....

(a) Residence: No. 3917 Gwynn Oak Ave St., ..... Ward.
(Usual place of abode) (If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. Color or Race | 5. Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| F | W | WIDOWED |

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of ELLSWORTH W. BOWEN

6. DATE OF BIRTH (month, day, year) JAN 3 1871

| 7. AGE Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|
| 76 | 0 | 21 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. HOUSEWIFE

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. .....

10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) KENT Co MARYLAND

FATHER

13. NAME JOSHUA A McCLARY

14. BIRTHPLACE (city or town) (State or country) KENT Co MD.

MOTHER

15. MAIDEN NAME SUSAN ANDERSON

16. BIRTHPLACE (city or town) (State or country) MARYLAND

17. INFORMANT Mrs. Robert SHADDICK

(Address) 3917 Gwynn Oak Ave Baltimore

18. BURIAL, CREMATION, OR REMOVAL

Chestertown Md. CHESTER CEM. Date JAN 26. 1947

19. UNDERTAKER J. Willis Wells

(Address) Chestertown, Md.

20. Filed JAN 24 1947 Huntington Williams, M.D.

### MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 1/24, 1947

22. I HEREBY CERTIFY, That I attended deceased from JAN, 1946, to JAN. 24, 1947

I last saw her alive on JAN. 23, 1947. Death is said to have occurred on the date stated above, at 11A m.

The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE | |
| | |
| | |

Other contributory causes of importance:

Was an operation performed? No Date of .....

For what disease or injury? .....

What test confirmed diagnosis? ..... Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19..

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify .....

(Signed) J. C. Pound M. D.

(Address) 3325 Frederick Ave

Information should be carefully supplied. State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G47854

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G47854

TN. 107787

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 641 Ensor St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Frances (Connelly) Connolly

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harry (Connelly) Connolly

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Aug. 12th., 1862

8. AGE: Years 83 | Months ? | Days 11 ? | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Michael Parr
13. Birthplace ? Germany

MOTHER
14. Maiden Name Eva Buttner
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 24, 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) JAN 24 1947 (b) Hamilton Baltimore, Md.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 23/1947 19 , at 9.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 20/ 19 47 , to Jan. 23 19 47 , and that I last saw her alive on Jan. 23/ 19 47 .

Immediate cause of death Confluent Bronchopneumonia

Due to Congestive Ht. Failure.

Due to Hypertensive C-V Disease Coronary Artery Disease.

Other Conditions Generalized Arteriosclerosis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

Duration

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert A. Farber M. D.
Address Balto. City Hosp. Date signed 1-25-47

VS 150

G47855

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

93E ✓

Registered No. G47855

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 27 N Carrollton Ave
(c) Hospital or institution:
6 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 27 N Carrollton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John M. Mc=Cahan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) ~~Single, married, widowed or divorced~~ Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31 1873

8. AGE: Years 73 | Months 6 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired Janitor

11. Industry or business Janitor Grocery

FATHER 12. Name Lorange Mc=Cahan

13. Birthplace Baltimore

MOTHER 14. Maiden Name Mary F. McDermott

15. Birthplace R. I.

16 (a) Informant Mary L. Mc=Cahan

(b) Address 27 N Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Old Frederick Rd.

18 (a) Funeral director John G Moran

(b) Address 3600 E Baltimore St

19 JAN 24 1947 (Date received by Registrar) (b) Huntington Williams, MD

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1947 at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1946 to Jan. 22 1946, and that I last saw him alive on Jan. 22 1946.

| | Duration |
|---|---|
| Immediate cause of death Bronchitis | 3 Weeks |
| Due to | |
| Due to | |
| Other Conditions Myocarditis - Acute myocardial failure (Include pregnancy within 3 months of death) | |

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Johnson M. D.

Address 701 N. Eutaw Date signed 1/24/47

V S 150

106B

G47856

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G47856

161a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Rural Town (If outside city or town limits, write RURAL and give town)
(d) Street No. 307 Stillwater Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARY ELIZABETH TUDOR

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/21/47

8. AGE: Years | Months | Days 1 | If less than one day hr. min.

9. Birthplace Balto. Co. Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER — 12. Name Wm Tudor
13. Birthplace Balto. Co. Md.

MOTHER — 14. Maiden Name Mildred L. Lacey
15. Birthplace Balto Md.

16 (a) Informant Wm Tudor
(b) Address 307 Stillwater Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location

18 (a) Funeral director Lanahan Funeral Home
(b) Address 7401 Baltimore Md

19 JAN 24 1947 Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/22 1947, at 11 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/21 1947, to 1/22 1947, and that I last saw h.E.R. alive on 1/22 1947

Immediate cause of death ATELECTASIS — Duration 1 DAY

Due to

Due to

Other Conditions POSSIBLE INTRACRANIAL HEMORRHAGE (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles W. Stewart Jr. M.D.
Address Md. Gen. Hosp. Date signed 1/24/47

VS 150

X

G47857

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

937

Registered No. G47857

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1520 Chesapeake Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 45
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 Chesapeake Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** George J. Beaumont

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-18-0808

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widower |

6 (b) Name of husband or wife Emma Donnelly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/16/1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 6. | 6 | hr. min. |

9. Birthplace Dublin, Ireland
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER 12. Name John Beaumont
13. Birthplace Ireland

MOTHER 14. Maiden Name Margaret O'Reiley
15. Birthplace Ireland

16 (a) Informant Mrs Catherine Kelly
(b) Address 1520 Chesapeake Ave.

17 (a) Burial, cremation, or removal (b) Date thereof 1/25/47.
(month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location Section 1 Lot 1 Grave 2

18 (a) Funeral director J. J. Lahey Sons
(b) Address 310 Light St.

19 JAN 24 1947 Huntington Williams M.D. Registrar
(Date received by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/22 1947 at 10:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/22 1947 to 1/22 1947 and that I last saw h[illegible] alive on 1/22 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral hemorrhage | |
| Due to Hypertension | |
| Due to Cardiovascular disease | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Robinson M. D.
Address 203 Paladia Ave Date signed 1/23/47

VS 150

G47858

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

8 3a

Registered No. G47858

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5023 Old Frederick Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5023 Old Frederick Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Rosa Jane Bowen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Joseph W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1868

8. AGE: Years 78 | Months 8 | Days 13 | If less than one day: hr. min.

9. Birthplace Calvert Co. Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER — 12. Name Harry Clay Dreland
13. Birthplace Md

MOTHER — 14. Maiden Name Sarah F. Bickhead
15. Birthplace Md

16 (a) Informant Mrs. Harry Hemmitt
(b) Address 5023 Old Fredk. Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 25/47 (month) (day) (year)
(c) Cemetery or crematory Calvary
Location Calvert County Md

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 E. Lanvale cor Pine

19 JAN 24 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22. 1947. at 8.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Jan 22 1947 and that I last saw h.e alive on Jan 22 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 1 wk |
| Due to Arteriosclerosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Edgar Talbert M. D.
Address 2773 St Paul's Date signed 1/29/47

VS 150

X

G47859

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G47859

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3107 Kenyon Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3107 Kenyon Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Joseph F. Savick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~. Married

6 (b) Name of ~~husband~~ or wife Josephine Savick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 6th 1902

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 44 | 10 | 17 | hr. min. |

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Coron Petrolatum Co

FATHER
12. Name Joseph F. Savick
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Palchar
15. Birthplace Md.

16 (a) Informant Josephine Savick
(b) Address 3107 Kenyon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/47 (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location Baltimore Md

18 (a) Funeral director Wilson Corp Inc
(b) Address 1317 N Carrol St

19 (a) JAN 25 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 1/23/47 19 at 3:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 1/24/47

VS 151

647860

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

109a

Registered No. 647860

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly:

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address 3520 Hilton Rd

(c) Hospital or institution: Ashburton Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1

(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3520 Hilton Rd

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

**3 (a). FULL NAME** Sadie Land

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1st 1867

8. AGE: Years: about 79 | Months: 8 | Days: 22 | If less than one day: hr. min.

9. Birthplace: Rock Hall Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name: Joseph Land

13. Birthplace: Rock Hall, Md

MOTHER — 14. Maiden Name: Mary

15. Birthplace

16 (a) Informant: Roland E. Land

(b) Address: 519 Dogwood Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1/29/47 (month) (day) (year)

(c) Cemetery or crematory: Mt Olivet

Location: Baltimore Md

18 (a) Funeral director: Wilbur Cook Sons

(b) Address: 1217 E Fayette

JAN 25 1947 (Date rec'd by Registrar) (b) Huntington Woods, Md Registrar

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Jan 23 1947, at 12 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22 1947 to 1-23-1947 and that I last saw h[illegible] alive on 1-23 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardiac Failure | 1 day |
| Due to Virus Pneumonia | 2 days |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Thomas Brown M. D.

Address 2424 Eutaw Place Date signed 1-24-47

BOUTON

G47861

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

92a

Registered No. G47861

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert St.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 42
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 626 Tunbridge Rd (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Walter S. Bouton

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Florence Bouton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 4, 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 71 | 4 | 19 20 | 8 hr. min. |

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation No known
11. Industry or business

FATHER
12. Name William Bouton
13. Birthplace Michigan

MOTHER
14. Maiden Name Mary Conklin
15. Birthplace Maryland

16 (a) Informant Wife
(b) Address 626 Tunbridge Rd

17 (a) Cremation (b) Date thereof 1/25/47
(Burial, cremation, removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St

19 Date received by local registrar JAN 25 1947 Huntington Williams M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1947 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1946 to Jan 24 1947 and that I last saw him alive on Jan 24 1947

| Immediate cause of death | Duration |
|---|---|
| Arterio-sclerotic heart disease | |
| Due to Aortic insufficiency | |
| Due to Decompensation | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence J. Knox M.D.
Address Mercy Hosp Date signed 1-24

K

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

647862

CWK-107214

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46F

Registered No. 647862

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 Years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 213 W. Biddle Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Elijah Barksdale

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Married |

6 (b) Name of husband or wife Eualah or Beulah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30-1904

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 42 | 9 | 21 | hr. min. |

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Lewis Barksdale
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Lane Dixon
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/26/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director A. Halstead
(b) Address 916 Druid Hill Ave.

19 JAN 25 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V S 150

## MEDICAL CERTIFICATION

P

20. DATE OF DEATH January 21 1947, at 4:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 31 1946, to Jan. 21 1947, and that I last saw h.im alive on Jan. 21 1947.

| Immediate cause of death | Duration |
|---|---|
| Malignant neoplasm of Liver | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Negative findings

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Dougl Walton M. D.
Address P.C.H. Date signed 1-22-47

X

G47863

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 929

G47863 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Ages, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 5

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 225 Silver Court.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Edna B. BOSTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | married |

6 (b) Name of husband or wife James H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 2, 1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | 7 | 19 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation House maid

11. Industry or business

FATHER
12. Name William Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Cora Smith
15. Birthplace Md.

16 (a) Informant James H. Boston
(b) Address 225 Silver Court.

17 (a) Burial (b) Date thereof 1/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Cemetery
Location Maryland.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) JAN 25 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-22-1947, at 1:40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 1/22/47

VS 151

G47864 AB-107824

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1243

Registered No. G47864

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 15yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 312 Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Hing, Yip of Hing, Hing Yip

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Chinese | Widower |

6 (b) Name of husband or wife — ? —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22-1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 11 | 1 | hr. min. |

9. Birthplace China
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Yit Lee or Yip Tei
13. Birthplace China

MOTHER
14. Maiden Name Chone
15. Birthplace China

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan-25-47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn

18 (a) Funeral director Stewart Memorial
(b) Address 108 W Mt. Royal Ave.

19 (a) JAN 25 1947 (Date rec'd by registrar) Clayton Williams Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25 1947, at 9:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22- 1947 to 1-25 1947, and that I last saw him alive on 1-25- 1947

| Immediate cause of death | Duration |
|---|---|
| Cardiac Failure | week |
| Due to Arteriosclerosis | yrs |
| Heart Disease | |
| Due to | |
| Other Conditions Cerebral Stroke | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.
Address Balt City Hosp Date signed 1/25/47

VS 150

927

647865

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 647865

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 212 Amity St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 Yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 212 Amity St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** George A Hawkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Mall | Col | Married |

6 (b) Name of husband or wife Clementine
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 8-13-1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 5 | 11 | ____ hr. ____ min. |

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name James Hawkins
13. Birthplace Md

MOTHER
14. Maiden Name Mary A. ?
15 Birthplace Md

16 (a) Informant Clementine Hawkins
(b) Address 212 amity St

17 (a) Burial (b) Date thereof 1 27 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Laurel Cem
Location Baltimore Md

18 (a) Funeral director Williams & Jackson
(b) Address 916 Penna ave

19 (a) JAN 25 1947 (b) [illegible]

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 24 1947, at 6:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1947 to Jan 24 1947 and that I last saw h[illegible] alive on 1/23 1947

| Immediate cause of death | Duration |
|---|---|
| (a) Uremia Myocardial Infarction | 2 |
| Due to (b) Hypertension | 9 |
| Due to (c) | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. M. Hatcher M. D.
Address 1725 Park Ave Date signed 1/24/47

V S 150

G47866

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 73a

Registered No. G47866

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2828 Riggs Ave.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2828 Riggs Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** EMMA ALT

3 (b) If veteran, name war: no
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George Alt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 22, 1866

8. AGE: Years: 81 | Months: 0 | Days: 1 | If less than one day: hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

MOTHER / FATHER
12. Name: George Schumann
13. Birthplace: Germany
14. Maiden Name: - Creasman
15. Birthplace: Germany

16 (a) Informant: Mr. George C. Alt, son
(b) Address: 6 Holmehurst Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/47 (month) (day) (year)
(c) Cemetery or crematory: Western Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 JAN 25 1947 (Date rec'd by registrar) (b) [signature] Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23, 1947, at 12:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-24-1941 to 1-23-1947 and that I last saw h[illegible] alive on 1-22-1947.

Immediate cause of death: Generalized Arteriosclerosis & Arterial Thrombosis - Multiple

Due to: Senile Anemia

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: Not Done

of autopsy: Not Done

| Duration |
|---|
| 1 year |
| 6 years |
| 1 year |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: [signature] M. D.
Address 1201 Eutaw Place Date signed 1-24-47

VS 150

G17867

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G47867 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4902 Reisterstown Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4902 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** BRENTEN E. GORSUCH

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| -no | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Laura H. Gorsuch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26, 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 7 | 27 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Lather
11. Industry or business Joseph Hitlichen, Builder

FATHER
12. Name Lee W. Gorsuch
13. Birthplace Md.

MOTHER
14. Maiden Name Eleanor Grimes
15. Birthplace Md.

16 (a) Informant Mr. Howard Gorsuch
(b) Address 2430 Frederick Rd.

17 (a) Burial (b) Date thereof 1/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Pleasant Cem.
Location Gamber, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address JAN 25 1947 Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 23 1947, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 22 1947, to JAN 23 1947, and that I last saw h.. alive on Jan. 23 1947.

| Immediate cause of death | Duration |
|---|---|
| CORONARY THROMBOSIS | 1 DAY |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Manuel Levin M. D.
Address 4818 Reisterstown Rd Date signed Jan 23/47

VS 150

G47868

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X ✓ 124 B

Registered No. G47868

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Worcester
(c) City or town Pocomoke
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** E. Carmel Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Lula C. Wilson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5 1903

8. AGE: Years 43 | Months 8 | Days 19 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Retail merchant

11. Industry or business Groceries

FATHER
12. Name Oliver Wilson
13. Birthplace Md

MOTHER
14. Maiden Name Emma Coleburne
15. Birthplace Md

16 (a) Informant Lula C. Wilson
(b) Address Pocomoke Md

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan 25 (month) (day) (year)
(c) Cemetery or crematory Salem M.E.
Location Pocomoke Md

18 (a) Funeral director Henry P. Watson
(b) Address Pocomoke City Md.

JAN 25 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 25 1947, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-13 1947 to 1-24 1947; and that I last saw him alive on 1-24 1947.

Immediate cause of death: Cardiac standstill — Duration

Due to: Hypertension & Oesophageal Varices

Due to: Portal Cirrhosis of Liver

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

**PHYSICIAN**
Underline the cause to which death should be charged, statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature H. Shallenberger M.D.
Address University Hospital Date signed 1-25-47

G47869
JL - 107791

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 127B

Registered No. G47869

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully reported. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 S. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Bonnie Hazel Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife Alexander Anderson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 0 | 29 | hr. min. |

9. Birthplace Ga.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Andy Bryant
13. Birthplace Tenn.

MOTHER
14. Maiden Name Caroline
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave,

17 (a) Burial (b) Date thereof Jan 27-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location
18 (a) Funeral director Charles P Powell
(b) Address Edmondson Ave.
19 (a) JAN 25 1947 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23, 1947, at 6.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 21, 1947 to Jan. 23 1947, and that I last saw her alive on Jan. 23 1947

Immediate cause of death: Severe obstructive jaundice; cause undetermined. — Duration: 3 wks.
Due to
Due to
Other Conditions: Secondary anemia due to Numerous hemorrhages
(Include pregnancy within 3 months of death)
Date of operation 1/23/47
Major findings of operation: Hepatomegaly
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:
23. Signature W. A. Gibbs
Address Baltimore City Hosp. Date signed 1/24/47 M. D.

VS 150

G47870 BC# G64827

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

158

G47870 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Anne Arundel
(c) City or town Crownsville State Hosp.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Margaret Marg Witt

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 1 | 13 45 | hr. min. |

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ekel Witt
13. Birthplace Virginia

MOTHER
14. Maiden Name Marie Trail
15. Birthplace Maryland

16 (a) Informant Marie Witt
(b) Address

17 (a) Burial (b) Date thereof 1/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore

18 (a) Funeral director Martin Fahey & Sons
(b) Address 1827 W. North Ave.

19 (a) [illegible] Williamsport Md.

JAN 25 1947

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 1/24 1947, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/17 1947, to 1/24 1947, and that I last saw h.e.r alive on 1/24 1947

Immediate cause of death Cardiac failure — Duration
Malignoma

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Sharpe Date signed 1/26/47

C47871
JL - 107828

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13B

Registered No. C47871

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 616 Dolphin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Annie Wilkerson

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1902

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 44 | 8 | 2 | hr. min. |

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert
13. Birthplace Md.

MOTHER
14. Maiden Name Mamie Digga
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn.
Location md

18 (a) Funeral director George H. Kilson
(b) Address 1303 Pennsylvania Ave

19 JAN 25 1947 (b) Hampton Williamson, M.D.

VS 150

**MEDICAL CERTIFICATION** A. M.

20. DATE OF DEATH Jan. 24, 1947, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 22 1947, to Jan. 24 1947, and that I last saw her alive on Jan. 24 1947.

| Immediate cause of death | Duration |
|---|---|
| Confluent [illegible] Meningitis probably Tuberculosis, | |
| Due to Pulmonary tuberculosis, | |
| probable | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Doyle Waldron M. D.
Address B. C. H. Date signed 1-24-47

X

G47872

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. G47872

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined before writing. Be sure that the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland Balto Md
(b) Street address 1732 Presstman
(c) Hospital or institution: — 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 Presstman St
(If rural give location)
(e) Citizen of foreign country? ——— (Yes or No)
If yes, name country ———

**3 (a) FULL NAME** Bettie Holman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | Col | Married |

6 (b) Name of husband or wife Charles Holman
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | | | hr. min. |

9. Birthplace Maryland Balto Md
(Town, county, and state)
10. Usual Occupation Home Wife
11. Industry or business —

FATHER
12. Name Jno Tosha
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace —

16 (a) Informant Charles Holman
(b) Address 1732 Presstman

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/26/46 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Leg. A. Kelson
(b) Address 1303 Presstman St

19 (a) JAN 25 1947 (Date rec'd by registrar) Thos. [illegible] Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 — 1947, at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 — 1947, to Jan 22 1947, and that I last saw h[illegible] alive on 1-22 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 2 hrs |
| Due to Hypertension, Nephritis | |
| Due to Arteriosclerosis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Wm R Boyd Jr M.D.
Address 1133 Monroe Date signed 1-24-47

VS 2

X

G47873

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 115 B

Registered No. G47873

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1214 Eutaw Place
(c) Hospital or institution: Baltimore Eye Ear Throat Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

**2. USUAL RESIDENCE OF DECEASED:** Formerly.
(a) State North Carolina County Pitt.
(c) City or town Fountain Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. ? Near Rocky Mount, N.C. 678 Pierce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mozella Adell Rogers

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | Negro | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1925

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 21 | 3 | 11 | hr. min. |

9. Birthplace Fountain, Pitt, North Carolina (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Manuel Rogers
13. Birthplace North Carolina

MOTHER
14. Maiden Name Elizabeth Bullock (Dead)
15. Birthplace North Carolina

16 (a) Informant Martha Hawkins (Sister)
(b) Address 678 Pierce St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Jan 25, 1947 (month) (day) (year)
(c) Cemetery or crematory Wilson N. C.
Location

18 (a) Funeral director Mrs. Katie V. Williams
(b) Address 220 N. Bethune St.

19 (c) JAN 25 1947 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 23 1947, at 6:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from JAN. 22 1947, to JAN. 23 1947, and that I last saw HER alive on JAN. 23 1947.

| Immediate cause of death | Duration |
|---|---|
| TOXEMIA DUE TO ACUTE PHARYNGO-TONSILLITIS | 15 hours (in hospital) |
| Due to BETA-HEMOLYTIC STREPTOCOCCUS | |
| Due to | |
| Other Conditions (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Steiner M. D.
Address Balto Eye, Ear, Throat Hosp. Date signed 1/23/47

VS 8

G47874 GARRISON ✓ G47874

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1211 Light St
(c) Hospital or institution: SDGH

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 da

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1749 Hanover St (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** Clara Garrison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Nelson E. Garrison

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Hse

11. Industry or business

FATHER 12. Name Thomas D. Loudenslager

13. Birthplace Balto Md

MOTHER 14. Maiden Name Mary Whittington

15. Birthplace Balto Md

16 (a) Informant Mr Nelson E. Garrison

(b) Address 1749 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-27-47 (month) (day) (year)

(c) Cemetery or crematory Glen Haven Cemetery

Location Glenburnie Md

18 (a) Funeral director Milton Schulling

(b) Address 3914 Hanover St

JAN 25 1947 (Date rec'd by Registrar) (Signature) Washington Williams M.D.

**MEDICAL CERTIFICATION** A

**20. DATE OF DEATH** 1-23 1947 at 2:10 AM

**21.** I certify that death occurred on the date above stated; that I attended deceased from 12-22 1946 to 1-23 1947 and that I last saw h. alive on 1-23 1947

| Immediate cause of death | Duration |
|---|---|
| Diabetes | |
| Gangrene | |
| Due to RF Leg | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23.** Signature H Broadhurst MD
Address 1211 Light St. Date signed 1-23 M. D. 47

VS 150

X

G47875

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

G47875 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4607 Hamphnett Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4607 Hamphnett Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Woollen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband ~~or wife~~ James R. Woollen

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Feb 20th 1875

8. AGE: Years 71 | Months 11 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at Home

FATHER
12. Name (UnKnown) Blessing
13. Birthplace Germany

MOTHER
14. Maiden Name Mary (UnKnown)
15. Birthplace "

16. (a) Informant James R. Woollen
(b) Address 4607 Hamphnett Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Oak Inc.
(b) Address 1217 St. Paul St.

19 (a) JAN 25 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24th 1947; at 4:15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 10 1946 to Jan 4 1947 and that I last saw h E R alive on Jan 24 1947

| Immediate cause of death | Duration |
|---|---|
| Arteriosclerotic | |
| Heart Disease | 5 years |
| Due to Senile changes | |
| arteriosclerosis | 10 years |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George Dawson M. D.
Address 4808 Harford Rd. Date signed 1/25/47

VS 150

647876

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. 647876

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert St
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 518 N. Payson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Hirt

3 (b) If veteran, name war Wld War I
3 (c) Social Security Account No. 213-05-9183

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Agnes Hirt
6 (c) If alive, give age / years

7. Birth date of deceased (mo., day, yr.) April 16 1897

8. AGE: Years 49 | Months 9 8 | Days 7 | If less than one day 19 hr. 20 min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Mechanic
11. Industry or business Bell System Co

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name /
15. Birthplace /

16 (a) Informant Agnes Hirt
(b) Address 518 N Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/47 (month) (day) (year)
(c) Cemetery or crematory Loraine
Location Baltimore Md

18 (a) Funeral director Wilson Co Inc
(b) Address 1319 E Oval St

19 JAN 25 1947 Hampton Williams MD
(Date received by local registrar) (Signature of local registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24 1947 at 7:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-24 1947 to 1-24 1947, and that I last saw him alive on 1-24 1947

| | Duration |
|---|---|
| Immediate cause of death Acute Congestive Heart Failure | |
| Due to Recurrent Coronary Thrombosis | |
| Due to Dm S Coronary | |
| Other Conditions Has been treated by outside physicians for Coronary (Include pregnancy within 3 months of death) | |

Date of operation None
Major findings of operations
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurence J. Kraft M. D.
Address Mercy Hosp Date signed 1-24-47

VS 150

X

G47877 5-27-02

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

46F

Registered No. G47877

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Give the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Fla (b) County
(c) City or town Miami, Fla
(If outside city or town limits, write RURAL and give town)
(d) Street No. 230 I St. Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar Rosenbaum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sophie Rosenbaum

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) 2-24-80

8. AGE: Years 66 | Months 11 | Days 0 | If less than one day: hr. min.

9. Birthplace Romania (Town, county, and state)

10. Usual Occupation Sign Painter

11. Industry or business

FATHER
12. Name Haskel ?
13. Birthplace Romania

MOTHER
14. Maiden Name ?
15. Birthplace Romania

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1-27-47 (month) (day) (year)

(c) Cemetery or crematory New York City
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1432 E Baltimore St

JAN 25 1947 (Date rec'd by registrar) Washington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-27-1947, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 7- 1947, to Jan 27 1947, and that I last saw h alive on Jan 25 1947

| Immediate cause of death | Duration |
|---|---|
| Uremia | 3 da |
| Due to Carcinomer of | ? |
| Amputation of Calf | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation 1/18/47 & 1/23/47

Major findings of operation: Same

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard C. Clay, M.D.
Address Johns Hopkins Hosp Date signed 1/27/47

VS 150

G47878

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

G47878 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 517 Wildwood Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 517 Wildwood Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Jane A. Gessler

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife John Jr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 21 1861

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 85 | 2 | 1 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business Gone

FATHER
12. Name John L. Conton
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Burke
15. Birthplace Ireland

16. Informant Wilhelmina L. Gessler
(b) Address 517 Wildwood Parkway

17 (a) Burial (b) Date thereof Jan 27 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Old Frederick Road

18 (a) Funeral director John G. Horan
(b) Address 3000 E Baltimore

JAN 25 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 23 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1946 to Jan 1947
and that I last saw h alive on Jan 23 1947.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary edema | |
| Due to Nephritis chronic | |
| Due to Pulmonary edema | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place)
While at work?
(e) Means of injury

23. Signature Chas. F. Bolek M. D.
Address 20 E Preston Date signed 1/29/47

VS 150

X

MARZOLA

G47879

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 61

Registered No. G47879

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 110 N. Wolfe St.
(c) Hospital or institution: [redacted] b

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 37

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 N. Wolfe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Antonietta Marzola

3 (b) If veteran, name war

3 (c) Social Security Account No. No

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Carmisso

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Aug 12 1884

8. AGE: Years 62 | Months 5 | Days 11 | If less than one day hr. min.

9. Birthplace Itasly
(Town, county, and state)

10. Usual Occupation At Home.

11. Industry or business

FATHER 12. Name Dominick Farmella

13. Birthplace Itasly

MOTHER 14. Maiden Name Marie DeAdno

15. Birthplace Italy

16 (a) Informant Carmisso Marzola

(b) Address 110 N. Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 27 47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location 4300 Belair Rd

18 (a) Funeral director Mario DeAngelis

(b) Address 378 S. Ann St.

JAN 25 1947 (Date received by Registrar) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 23 1947 at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1947 to Jan 23 1947, and that I last saw h alive on Jan 23 1947

Immediate cause of death Cerebral Hemorrhage — Duration 1 hr.

Due to Essential Hypertension — ?

Due to

Other Conditions Diabetes Mellitus — ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Britt M. D.

Address 1221 N. Luzerne Ave Date signed 1/24/47

VS 150

83a

G47880 Eckardt

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 48a

Registered No. G47880

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Winkler ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MRS. ELSBETH ECKARDT

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | M |

6 (b) Name of husband ~~or wife~~ Mr. Albert Eckardt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-28-89.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 8 | 26 | hr. min. |

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER
12. Name Gottlieb Wagemer
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothy Brandt
15. Birthplace Germany

16 (a) Informant Mr albert Eckardt
(b) Address 1205 Winkler ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 21 '47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director Harry N Wetzler
(b) Address 4101 Edmondson ave

JAN 25 1947 by Huntington Williamson, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-23- 1947 at 10 04 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-13- 1947 to 1-23 1947 and that I last saw h~~e~~r alive on 1-23- 1947

| Immediate cause of death | Duration |
|---|---|
| Apoplexy; | |
| Carcinomatosis | |
| Due to | |
| Due to | 1 week |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 1-14-47
Major findings of operation: Carcinomatosis
of autopsy: Same

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature R. L. Hunkley M.D.
Address Bon Secours Hosp. Date signed 1-23.

VS 190

G47881

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH √87E

G47881 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Bukeland + Rayner Ave
(c) Hospital or institution: West Balto Gen'l Hosp No
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 Rosedale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** WALTER E. FORD

1-24-47

**MEDICAL CERTIFICATION**

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Minnie Roe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28 1893

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | 3 | 26 | hr. min. |

9. Birthplace Pittsburgh Pa (Town, county, and state)
10. Usual Occupation Window Shades
11. Industry or business "

FATHER
12. Name Augustus Ford
13. Birthplace Conn

MOTHER
14. Maiden Name Edna C. Gallion
15. Birthplace Balto

16 (a) Informant Minnie Roe Ford
(b) Address Conn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jany 26/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem
Location Pikesville Md

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1904 Eutaw Place

JAN 25 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

**20. DATE OF DEATH** 1-24-47 19 at 12 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-14-47 19 to 1-24 19 47, and that I last saw h[illegible] alive on 1-24 19 47.

| Immediate cause of death | Duration |
|---|---|
| Depressed Intracranial Fracture L | |
| Due to Undetermined Origin | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Depressed Intracranial Hem

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Berdinsky M. D.
Address West Balto Gen'l Hosp Date signed 1/24/47

VS 150

G47882

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G47882

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied—the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto.
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 Edgerton Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Emma Belle Gallagher

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: Single
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 10, 1884
8. AGE: Years 62 | Months 7 | Days 14 | If less than one day hr. min.
9. Birthplace New York (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Rev. George Gallagher
13. Birthplace New York

MOTHER
14. Maiden Name Emma Smith
15. Birthplace New York

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jany 27/47 (month) (day) (year)
(c) Cemetery or crematory Oakwood Cemetery
Location Bay Shore L.I. N.Y.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1911 Eastern Place

19 JAN 25 1947 [illegible] Williamsport Md
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 24 1947 at 6:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 23 1947 to Jan 24 1947 and that I last saw h[illegible] alive on Jan 24 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage, accident | |
| Due to Hypertensive Vascular Disease | |
| Due to Generalized Arteriosclerosis | |
| Other Conditions Angina | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice A. Stentzel M. D.
Address [illegible] Date signed 27 Jan. 47

VS 150

G47883 JL - 105824 BC# G 89365 BALTIMORE CITY HEALTH DEPARTMENT 13B Registered G47883

# CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 -11
(e) Length of stay in Baltimore (yrs., mos., or days) 12 mos.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 708 N. Caroline St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Joseph Talley

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 1 | 0 | 21 | hr. min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Frank Gale Talley
13. Birthplace Va.

MOTHER
14. Maiden Name Josephine Talley
15. Birthplace Va.

16 (a) Informant B. C. H. records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Brantley Ave

JAN 25 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23 1947, at 7.10A M

21. I certify that death occurred on the date above stated; that I attended deceased from D. C. 12 1946, to Jan. 23 1947, and that I last saw him alive on Jan. 23 1947.

| Immediate cause of death | Duration |
|---|---|
| Circulatory Collapse | 1 hr. |
| Due to Miliary Tuberculosis | 2 mos. |
| Due to | over |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Julian P. Thuffin M. D.
Address Balt. City Hosp. Date signed 23 Jan 1947

VS 150

G47884

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

G47884 Registered No.

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1829 Jefferson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Elizabeth Bias

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years 36 | Months | Days | If less than one day hr. min.

9. Birthplace Elizabeth City, N.C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden Name Mary Jones

15. Birthplace Elizabeth City N.C.

16 (a) Informant Friends

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Jan. 27, 1947 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem.

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1517 Orleans St

19 JAN 25 1947 (Date filed by Registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION** 15

20. DATE OF DEATH Jan. 23 1947 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 23 1947 to Jan. 23 1947 and that I last saw him alive on Jan. 23 1947

Immediate cause of death Uremia — Duration

Due to Arteriosclerotic and hypertensive cardio vascular

Due to Renal disease — 4 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy as above

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Isaacs M. D.

Address Johns Hopkins Hosp. Date signed 23 Jan. 47

VS 150

X

G47885

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G47885

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. 15
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5000 Pembridge St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Rebecca Fink

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | (S) M W D |

6 (b) Name of husband or wife Carl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

| 8. AGE: Years | Months | Days | If less than one day: hr. | min. |
|---|---|---|---|---|
| 65 | | | | |

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name Nathan Hollander
13. Birthplace Russia
14. Maiden Name Warren
15. Birthplace Russia

16 (a) Informant Nathan Fink
(b) Address 2020 Westwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-47 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herring Run

18 (a) Funeral director Jack Levin Inc
(b) Address 109 E Baltimore St
(c) Date rec'd by registrar JAN 25 1947 Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-23 1947, at 11:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-21 1947 to 1-23 1947 and that I last saw h[illegible] alive on 1-23 1947.

Immediate cause of death: Acute Cardiac failure — Duration

Due to acute Cardiac failure, Preliminary Edema — Duration

Due to Arteriosclerotic degeneration Myocardial disease — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Findings of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Hollander M.D.
Address University Hospital Date signed 1-23-47

VS 150

G47886 BC# G 18823 BALTIMORE CITY HEALTH DEPARTMENT G47886 Registered No. 105

# CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Anne Arundel
(c) City or town Parleigh Heights Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Resident of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Bessie Thompson

3 (b) If veteran, name war | 3 (c) Social Security Account

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife | 6 (c) If wife, give maiden name

7. Birth date of deceased (mo., day, yr.) 2-25-[illegible]

| 8. AGE: Years | Months | Days | If less than one day: hr. | min. |
|---|---|---|---|---|
| 21 | | | | |

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name

13. Birthplace

14. Maiden Name Rosetta Thompson

15. Birthplace

16 (a) Informant Rosetta Thompson
(b) Address Parleigh Heights

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 27/47 (month) (day) (year)
(c) Cemetery or crematory Townsend
Location Leading Park

18 (a) Funeral director J. B. Johnson
(b) Address [illegible]

JAN 26 1947 [illegible] Washington Williams, M.D. Local registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 25 1947, at 8:50 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 1946 to Jan 25 1947, and that I last saw [illegible] alive on [illegible] 1947

Immediate cause of death Pneumonia
Following Acute Lobar Pneumonia
Due to Pulmonary Tuberculosis

Due to

Other Conditions Congestive Heart Failure

Operation (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Y Nasenbeny M.D.
Address University Hosp Date signed 1/27/47

G47887

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 55E

G47887

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1211 Light St
(c) Hospital or institution: So Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18da
(e) Length of stay in Baltimore (yrs., mos., or days) ?

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4527 Homer Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Benjamin Melman

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife Anna Rose Melman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1897

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 10 | 21 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business Bakery Business

FATHER
12. Name David Melman
13. Birthplace Russia

MOTHER
14. Maiden Name Anna Cohen
15. Birthplace Russia

16 (a) Informant Anna Rose Melman
(b) Address 4527 Homer Ave

17 (a) Burial (b) Date thereof Jan 26, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Date received Baltimore, Md
(b) Registrar

**MEDICAL CERTIFICATION** 355

20. DATE OF DEATH 1/24/47 1947 at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6 1947, to 1-24 1947 and that I last saw h[illegible] alive on 1-24 1947

| Immediate cause of death | Duration |
|---|---|
| Reticulum Cell Sarcoma | |
| Due to | |
| Due to | yrs |
| Other Conditions Diabetes mellitus, Hypertension Arteriosclerosis | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Cohen M. D.
Address Sinai Beth Cho Hosp Date signed 4 Jan 47

VS 150

G47888

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G47888
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution Mt Sinai Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) All yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2517 Liberty Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Emil Rosenthal

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Regina
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | | | hr. min. |

9. Birthplace Germany (Town, county, state or country)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name unknown
13. Birthplace Germany

MOTHER 14. Maiden Name unknown
15. Birthplace Germany

16 (a) Informant Harry Hyman
(b) Address 2517 Liberty Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-47 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Friendship Cem.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Baltimore St

19 (a) 1947 (Date rec'd by Registrar) Hamilton Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-24- 1947; at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10, 1946 to Jan 24, 1947 and that I last saw h[illegible] alive on Jan 24, 1947.

| Immediate cause of death | Duration |
|---|---|
| Chronic Myocarditis | |
| Due to Arteriosclerotic Cardiovascular Disease | |
| Due to | |
| Other Conditions Diabetes Mellitus | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 1331 E. South ave Date signed 1-25-47

VS 150

93D

G47889 BALTIMORE CITY HEALTH DEPARTMENT G47889

# CERTIFICATE OF DEATH

Registered No. 1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1820 E Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2820 E Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Slebzak

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Anthony

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 70 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Rose Rybzynski
15. Birthplace Poland

16 (a) Informant Mrs. M. Zakrzewski
(b) Address 2820 E Baltimore St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Jan 27 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Frank W Ozarowski
(b) Address 1930 Eastern Ave.

19 (a) (Date received by registrar) (b) Huntington Will Registrar, M.D.

JAN 29 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1947, at 7:30 pm M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1946 to Jan 23 1947, and that I last saw her alive on Jan 23 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 6 hours |
| Due to Arteriosclerosis | Unknown |
| Due to Myocarditis | " |
| Other Conditions Nephritis | " |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philbert Arlyanne M. D.
Address 2942 E. Fayette Date signed 1/28/47

93D

G47890

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 52a

G47890 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3712 Parkside drive
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3712 Parkside Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Anna Marie Weber (Wendeler)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Walter Wendeler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28-1877

8. AGE: Years 69 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER 12. Name William Weber
13. Birthplace Germany

MOTHER 14. Maiden Name Dont Know
15. Birthplace Germany

16 (a) Informant Herman Weber
(b) Address 3712 Parkside drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 27th (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location City

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

19 (a) JAN 26 1947 (Date rec'd by registrar) (b) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 24th 1947, at 8-45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 26 1946 to Jan 24 1947 and that I last saw h.. alive on Jan 20 1947

Immediate cause of death: Carcinoma Kidney (A) — Duration: 1 years

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. S. Harding M. D.
Address 4810 Belair Rd Date signed 1/25/47

Washington-Wilmette, Inc.

X

G47891

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47891 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2701 E. Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2701 E. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Gustavus P. Fetty

3 (b) If veteran, name war —

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W. | Widowed |

6 (b) Name of husband or wife Mary P. Fetty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12th 1860

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 87 | - | 12 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Stationary Brick Yard
11. Industry or business

FATHER 12. Name Dont Know
13. Birthplace —

MOTHER 14. Maiden Name Dont Know
15. Birthplace "

16 (a) Informant Marion Laughlin
(b) Address 3074 Robinson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 27 (month) (day) (year)
(c) Cemetery or crematory Pt. Lookout
Location Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (b) (Date received by registrar) Registrar
1-26-1937 Huntington Williams, MD

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 24 1937, at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1 1936 to 1-24 1937 and that I last saw him alive on 1-24 1937

| Immediate cause of death | Duration |
|---|---|
| Myocarditis | |
| Due to arteriosclerotic heart disease | |
| Due to arteriosclerosis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John J. Gould M. D.
Address 14 N. Eastern Date signed 1-25-37

X

G17892

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 102

Registered No. G17892

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in this institution (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County —
(c) City or town Baltimore - 23, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 414 Fontaulk Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Verna Lovelace

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. SEX F | 5. COLOR OR RACE W | 6. (a) Single, married, widowed, or divorced Married

(b) If married, widowed, or divorced, husband of (or wife of) Edgar Lovelace

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1878.

8. AGE: Years 68 | Months 1 | Days 3 | If less than one day hrs. min.

9. Birthplace Pittsburgh, Pa.
(Town, county, and State or foreign country)

10. Usual Occupation Housewife

11. Industry or business —

12. Name of father Wm Emory Peregoy

13. Birthplace of father Baltimore, Md.

14. Maiden Name of mother Mary Rebecca Lawyer

15. Birthplace of mother Hobson Grove, Md.

16 (a) Informant Wm E. Peregoy

(b) Address Reisterstown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 27, 1947. (Month) (Day) (Year)

(c) Cemetery or crematory Reisterstown Methodist

Location Reisterstown, Md.

18 (a) Funeral director Wm Berry and Sons

(b) Address Reisterstown, Md.

1-26 1947 (b) Hampton Williams, M.D.
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-24 1947

21. I certify that death occurred on the date above stated, that I attended deceased from 1-21 1947 to 1-24 1947, and that I last saw h[illegible] alive on 1-24 1947

**PART I. DEFINITION OF IMMEDIATE CAUSE OF DEATH:**

The disease or condition which directly caused death. Duration: 2 days.

Antecedent causes: Morbid conditions, if any, giving rise to the immediate cause of death. Post-operative shock

Due to Hypertension

Due to

**PART II. OTHER CONDITIONS OF CONSIDERABLE IMPORTANCE:**

Other conditions contributing to death but not related to the disease or condition causing death.

Date of operation 1-23-47 (Include operations within 3 months of death)

Major findings of operation Carcinoma Stage 2

**PHYSICIAN**

Address the Registrar of the City or County in which death should be registered. If death is more than one cause contributing to the death, the physician is expected to underline that particular one which should be charged for purpose of statistical tabulation.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B. Morrison M. D.
Address Univ. Hosp. Date signed 1-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G47893

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 92a

G47893 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address UNIVERSITY HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 39days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 710 W. Saratoga St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** FERDINAND BARRETT

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | C | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/29/1903

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 43 | 8 | 29 | hr. min. |

9. Birthplace B.W.I.
(Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mary Ida Lane
(b) Address 817 W.Fairmount Ave

17 (a) Burial (b) Date thereof 1/26/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Catonsville, Md

18 (a) Funeral director Charles G.Cooper
(b) Address 510-512 N.Carrollton Ave

19 (a) 2[illegible] (b) [illegible] Registrar
(Date received by city registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH JAN. 22 1947, at 2 [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from NOV. 17 1946, to JAN 22 1947, and that I last saw h[illegible] alive on JAN 22 1947.

| Immediate cause of death | Duration |
|---|---|
| CARDIAC DECOMPENSATION | |
| Due to CARDIO-VASCULAR DIS. | |
| Due to AORTIC INSUFFICIENCY | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R.L. Bower M. D.
Address University Hosp. Date signed 1-23-47

X

G47894

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46E

G47894 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2520 Edmondson Ave.
(c) Hospital or institution: Mercy Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2520 Edmondson ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs Minnie (Edmonson) Hassan

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Widow |

6 (b) Name of husband or wife Thomas Hassan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1869

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | Jun | 4 | hr. min. |

9. Birthplace Chicago, Ill.
(Town, county, and state)
10. Usual Occupation H W.
11. Industry or business

FATHER
12. Name Charles Carla
13. Birthplace Md.

MOTHER
14. Maiden Name Fanny Brennan
15. Birthplace Md.

16 (a) Informant Frank Carla
(b) Address - 2520 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/47 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Old Frederick Rd

18 (a) Funeral director J. Bailey Keyes
(b) Address 1216 Light St.

19 (a) 1/26 1947 (b) Clayton Williams Registrar
Received by registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/24/47 19 , at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/23 1947 to 1/24 1947, and that I last saw h[illegible] alive on 1/24 1947.

Immediate cause of death: Respiratory failure — Duration: 3 hrs

Due to: Intestinal obstruction — 6 days

Due to: malignant tumor

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation 1/23/47
Major findings of operation: Tumor growth of colon
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature August Klink M. D.
Address Mercy Hosp Date signed 1/[illegible]/47

G47895 BC# G67294

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 182a

G47895 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 Llewellyn ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN AMELIA FORREST

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 2-1947

8. AGE: Years | Months | Days 21 | If less than one day ____hr. ____min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Charles Wesley Forrest
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Celia Idarmon
15. Birthplace Baltimore Md.

16 (a) Informant Charles Wesley Forrest
(b) Address 1627 Llewellyn Ave

17 (a) Burial (b) Date thereof Jan 27-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Moreland Manors
Location Balto Md

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

(Date) 1-28 1947 rec'd by registrar [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28th 1947, at 6:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Mechanical Suffocation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-23-47 at 5:30 P.M.
(b) Where did injury occur? 1627 Llewellyn Ave
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Suffocated by bedclothes

23. Signature Helge K. Morrell M.D.
Medical Examiner.

Date signed 1/24/47

VS 151

Write the causes of death clearly and legibly. Exact age is especially important. Physicians: please write

G47896

Birth Certificate 22-68702

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1610

G47896 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE & JOHN STS.
(c) Hospital or institution: WOMENS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 HRS. 36 MIN.
(e) Length of stay in Baltimore (yrs., mos., or days) 11 HRS. 36 MIN.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town JOPPA (If outside city or town limits, write RURAL and give town)
(d) Street No. RING FACTORY ROAD (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME BABY PEARCE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN 25 1947

8. AGE: Years | Months | Days | If less than one day 11 hr. 36 min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name HARRY WILLIAM PEARCE
13. Birthplace BALTIMORE MD.

MOTHER
14. Maiden Name BEATRICE ALBERTA LEIGHT
15. Birthplace BALTIMORE MD.

16 (a) Informant HOSPITAL RECORDS
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/47 (month) (day) (year)
Cemetery or crematory Edgewood Cemetery
Location Harford Co.

18 (a) Funeral director Howard M. Gracham
Aberdeen Md.

19 (a) 26 1947 (Date rec'd by registrar) (b) Hilton Hillegas Mill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 25 1947 at 7:12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 25 1947 to JAN 25 1947 and that I last saw HIM alive on JAN 25 1947

Immediate cause of death: CARDIO-RESPIRATORY FAILURE — Duration 11½ HRS

Due to CONGENITAL ATELECTASIS

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy CONGENITAL ATELECTASIS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James N. McCosh M. D.
Address Women's Hospital Date signed 1/26/47

VS 2 Taken by Julia C Holland Co, Baltimore Md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correctness of is especially important. Physicians: please write the causes of death clearly and legibly.

G47897

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46E

G47897 Registered No.

Every item of information should be carefully supplied. The entire age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3630 Cottage Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3630 Cottage Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Wolfe Kotzen

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gertrude
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Lark
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant: Gertrude Kotzen
(b) Address 3630 Cottage Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-26-47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem Pk
Location Lemmon

18 (a) Funeral director Jack Levy Inc
(b) Address 1439 E Balto St

19 (a) JAN 26 1947 (Date) (b) Washington Williams, M. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-26- 1947 at HA M

21. I certify that death occurred on the date above stated, that I attended deceased from 1/10 1946 to 1/26 1947.
and that I last saw him alive on 1/24 1947.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of Colon | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Krauskopf M. D.
Address 122 W. Lee St Date signed 1/26/47

VS 150

G47898

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 463

G47898
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 24 So Washington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 24 So Washington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Harry Hurwitz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 69 | Months | Days | If less than one day: hr. min.

9. Birthplace Lith. (Town, county, and state)

10. Usual Occupation Paper Hanger

11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Lith.

MOTHER
14. Maiden Name Bessie
15. Birthplace Lith.

16 (a) Informant Mary Hurwitz
(b) Address 24 So Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-27-47 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Old Furnace Rd Lot

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Fulton St.

19 (a) (Date rec'd by Local Registrar) (b) Huntington Williams, M.D. Registrar

JAN 26 1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-26- 1947, at 12 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 26 1946 to Jan 26 1947, and that I last saw h.. alive on Jan 24 1947

Immediate cause of death: Malnutrition, Senility then — Duration: Few months

Due to: Carcinoma of Stomach — 6 mos

Due to:

Other Conditions: Cirrhosis of Liver

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature A. F. Rees M. D.
Address 24 S. Bway Date signed Jan 26/47

G47899

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 53

G47899
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lexington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Jennie Suntilla or Sumitlla

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Nicholas Suntilla
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3rd 1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 8 | 22 | hr. min. |

9. Birthplace Napoli
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Paolo Curzio
13. Birthplace Italy

MOTHER
14. Maiden Name Anna Magnano
15. Birthplace Italy

16 (a) Informant Nicholas Suntilla (Husband)
(b) Address 1624 E. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Janu.26 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.
18 (a) Funeral director Frank Della Fosse
(b) Address 52 N. Morley St

JAN 25 1947 (Date received by Registrar) (b) Registrar
Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan. 25, 1947, at 11:15 A.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan. 19 1947 to Jan. 25, 1947 and that I last saw her alive on Jan. 25, 1947

Immediate cause of death: Pulmonary Embolism — Duration: 1 Week

Due to: Metastasis — Carcinoma of Rectum — 4 yrs. (?)

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23. Signature** Harry Levin M. D.

Address 14 S. Broadway Date signed 1/25/47

G47900

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

Registered No. G47900

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 490 S. Brunswick Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 490 S. Brunswick Street
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

**3 (a) FULL NAME** WILLIAM H. DAILEY

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) Aug. 11-1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 5 | 12 | ********** hr. min. |

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Baltimore Transit Empl

FATHER
12. Name Henry Dailey
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Unknown
15 Birthplace Baltimore Maryland

16 (a) Informant Joseph Dailey
(b) Address 9 Beachfield Ave.

17 (a) Burial (b) Date thereof Jan. 27. 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathederal
Location Baltimore Maryland

18 (a) Funeral director F. B. Wippert & Son.
(b) Address 1300 Eutaw Place...17

(Signature) (b)
(Signature of registrar) Registrar

1-26-1947

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 23, 1947, at P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1943 to Jan 23 1947 and that I last saw him alive on Jan. 23, 1947

Immediate cause of death Cerebral Hemorrhage — Duration 2 days
Due to Generalized Arterio Sclerosis — 10 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herman Sherman, M.D.
Address 2424 Eutaw Place Date signed 1/26/47 M. D.

Dr. Sherman

C47901

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

C47901 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Raynor Ave. & Dukeland St.
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) –

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 51 S. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs. Francis Buschman

3 (b) If veteran, name war –
3 (c) Social Security Account No. –

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Theodore Buschman
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) April 1, 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 9 | 25 | 24 hr. min. |

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Frederick Brick
13. Birthplace Germany

MOTHER
14. Maiden Name Adelaide Schwartz
15. Birthplace Germany

16 (a) Informant Theodore Buschman
(b) Address 51 S. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 28 '47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Baltimore Md.

18 (a) Funeral director F. B. Wisbert & Son
(b) Address 1302 Eutaw Place

19 (a) JAN 27 1947 (Date received by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25, 1947 at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 13, 1947 to Jan. 25, 1947, and that I last saw her alive on Jan. 25, 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardio-respiratory failure | |
| Due to Diabetic arteriosclerotic cardiovascular disease | |
| Due to Diabetes mellitus | |
| Other Conditions Ascites, Uterine Fibroma (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leon Toby M.D.
Address West Balto. Gen. Hosp. Date signed 1/25/47

Transcriber for Hilliard, Registrar

VS 150

G47902 BC# 67935 36

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

Registered No. G47902

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MARYLAND (b) County
City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3903 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARY MARGARET BARRY

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| NONE | NONE |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| FEMALE | WHITE | SINGLE |

6 (b) Name of husband or wife NONE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JANUARY 13, 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 0 | 0 | 12 | hr. min. |

9. Birthplace BALTIMORE, MARYLAND (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name JOHN MARSHALL BARRY
13. Birthplace BALTIMORE, MARYLAND

MOTHER
14. Maiden Name ANNETTE I. STOUT
15. Birthplace BALTIMORE, MARYLAND

16 (a) Informant FATHER
(b) Address 3903 GREENMOUNT, 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 27/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director John F. Moran
(b) Address 3660 Baltimore St

19 JAN 27 1947 Registered by Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 25 1947 at 9:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from JANUARY 13 1947 to JANUARY 25 1947 and that I last saw HER alive on JANUARY 25 1947.

Immediate cause of death DIARRHEA OF NEWBORN, NON-SPECIFIC — Duration 7 Days
Due to
Due to
Other Conditions PREMATURITY — 13 Days
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Latimer H. Garing M. D.
Address Union Memorial Hosp Date signed 1/25/47

VS 150

119a

G47903

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 112

Registered No. G47903

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 20th Broadway.
(c) Hospital or institution: David Hunt Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 E Arlington Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Miss Georgina Logue.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1, 1931

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 15 | 1 | 23 | hr. min. |

9. Birthplace Philadelphia, Pa.
(town, county, and state)

10. Usual Occupation Student

11. Industry or business Student

FATHER
12. Name Mr. John Logue.
13. Birthplace Philadelphia Pa

MOTHER
14. Maiden Name Kathryn Murphy.
15. Birthplace Philadelphia Pa

16 (a) Informant Mr. John Logue
(b) Address 511 East Arlington Ave.

17 (a) Burial (b) Date thereof 1/28/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Old Cathedral
Location Paula Pa

18 (a) Funeral director John A. Larson
(b) Address 3 West Baltimore St

19 JAN 27 1947
(Date received by registrar) Huntingdon Withheld M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 24 1947, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1947 to Jan 24 1947 and that I last saw him alive on Jan 24 1947.

| Immediate cause of death | Duration |
|---|---|
| Acute Cardiac Dilatation | 2 hr. |
| Due to Asthma | 12 yrs. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Bachenheimer M. D.

Address David Hunt Hosp. Date signed Jan 27 47.

G47904

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47904 Registered No. 1248

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 109 S. Monroe Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Fefel

3 (b) If veteran, name war: W.W #1

3 (c) Social Security Account No. 717-17-0938

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Seperated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN 13-1893

8. AGE: Years 54 | Months 0 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John O Fefel
13. Birthplace Balto Md

MOTHER
14. Maiden Name Alice Geltmacher
15. Birthplace Balto Md

16 (a) Informant John O. Fefel
(b) Address 2015 Ramsay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 27-1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral Director Roll & B.M. Walter
(b) Address Pratt & Stricker Sts

19 (a) (Date received by Registrar) JAN 27 1947 Registrar for Baltimore, Md.

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 24, 1947, at 9.15 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Edema
Coronary Disease
Due to Fatty Liver

Other Conditions: Generalized Arterio-sclerosis.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 1-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47905

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 107

Registered No. G47905

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 411 S Mount St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto City (If outside city or town limits, write RURAL and give town)
(d) Street No. 411 S Mount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Harry Leverton Stevens

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30 1869

8. AGE: Years 77 | Months 3 | Days 25 | If less than one day ____hr. ____min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Iron Man

11. Industry or business

FATHER 12. Name Harry L.
FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Bessie Cromwell
MOTHER 15. Birthplace Md

16 (a) Informant Mr Stevens
(b) Address 2105 Maiden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director Edward Foulger
(b) Address 359 Work Blvd

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 JAN 27 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24 1947, at 3:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/24 1947, to 1/24 1947, and that I last saw h alive on 1-24 1947.

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia | 2 days |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Miller M. D.
Address 20 W Williams Date signed 1/24/47

Contractor Williams M.D.

avr X

G47906

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13B

G47906 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 12 W. Oliver St
(c) Hospital or institution: * * * 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) *
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 12 W Oliver St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Joseph A McCormick

3 (b) If veteran, name war * *

3 (c) Social Security Account No. * *

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary B McCormick

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Mar 29 - 1889

8. AGE: Years 57 | Months 9 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Test: Keeper

FATHER
12. Name Patrick McCormick
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Hand
15. Birthplace Maryland

16 (a) Informant Mrs Mary B. McCormick
(b) Address 12 W. Oliver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof JAN 27 47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Chas. F. Evans - Son
(b) Address 118 W. Mt Royal Ave.

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

JAN 27 1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/24 1947 at 4 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/21 1947, to 1/24 1947, and that I last saw him alive on 1/23 1947.

| Immediate cause of death | Duration |
|---|---|
| Uremia & Congestion Bronchial Pneumonia | 3 weeks |
| Due to Bilateral Pyelonephritis | 1 year |
| Due to | |
| Other Conditions — | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas A. Hunter Jr. M. D.

Address 102 S. Calvert St. Date signed 1/25/47

Hunter for Williams M.D.

X

G17907 BG# F86779

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13B

Registered No. G17907

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hospital W
(d) Length of stay in hospital or institution (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1831 Edmondson (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Barber

3 (b) If veteran, name war
3 (c) Social Security Account No. Number

4. Race: Negro
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/14/43

8. AGE: Years 3 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Joseph Parker
13. Birthplace Va.

MOTHER
14. Maiden Name Carrie Lankester
15. Birthplace Virginia

16 (a) Informant Mrs. Carrie Parker
(b) Address 1831 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 27, 1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1691 Druid Hill Ave.

JAN 27 1947 (b) Huntington Williams M.D.
(Date received by registrar) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 23 1947, at 6 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15/1947 to 1/23/1947, and that I last saw h[illegible] alive on 1/23/1947

| Immediate cause of death | Duration |
|---|---|
| Respiratory Failure | 15 days |
| Due to Communicating Hydrocephalus | |
| Due to Basilar Tuberculous Meningitis | |
| Other Conditions Pulmonary Tuberculosis | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
Date of autopsy Communicating Hydrocephalus Basilar Tuberculous Meningitis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Hall M. D.
Address University Hosp Date signed 1/24/47

Balt-Md X

G47908

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47908 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 626 Fletcher St
(c) Hospital or institution: 14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town write RURAL and give town)
(d) Street No. 626 Fletcher St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary E. Snell

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | C | Widow |

6 (b) Name of husband or wife Unknown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 75 | 11 | 2 | hr. min. |

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name — Unknown
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Maryland

16 (a) Informant Mrs. Mary Clare
(b) Address 626 Fletcher St

17 (a) Burial (b) Date thereof Jan 29, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md

18 (a) Funeral director Wm. George A. Hall
(b) Address 1631 North Milton Ave

19 (a) JAN 27 1947 (b)
Registered by Registrar

VS 181

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** January 26 1947, at 9:00 P.M.

**21.** I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Kelly M.D.
Medical Examiner
Date signed Jan 26-1947

C47909

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 469

Registered No. C47909

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2450 Woodbrook
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Sarah Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Black | Married |

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-20-83

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 2 | 2 | hr. min. |

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ? Green
13. Birthplace ?

MOTHER
14. Maiden Name ? ?
15. Birthplace ?

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Jan. 27, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Geo. L. Hallam
(b) Address 1601 Druid Hill Ave.

19 JAN 27 1947 (b)
(Date received by Local Registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1947 at 12:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1947 to Jan 22 1947 and that I last saw her alive on Jan 22 1947

| Immediate cause of death | Duration |
|---|---|
| Obstruction of hepatic duct | |
| Due to Carcinoma - original site prob. in pancreas | 3 yrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E. Mason M.D.
Address Johns Hopkins Hosp. Date signed 22 Jan 47

VS 150

X

G47910
507994

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 132

Registered No. G47910

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1921 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lawrence Anthony

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Anthony
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) 9-15-1901

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | 5 | 11 | hr. min. |

9. Birthplace: North Carolina (Town, county, and state)
10. Usual Occupation: Laborer
11. Industry or business

FATHER
12. Name: Daniel Anthony
13. Birthplace: North Carolina

MOTHER
14. Maiden Name: Lucy Anthony
15. Birthplace: North Carolina

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan. 26, 1947 (month) (day) (year)
(c) Cemetery or crematory: Arbutus Mem. Park
Location: Baltimore, Md.

18 (a) Funeral director: Mrs. George H. Hubbard
(b) Address: 1631 Druid Hill Ave.

19 (a) JAN 27 1947 (b) Registered
Registrar

VS 130

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 26 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 13 1947 to Jan. 26 1947 and that I last saw him alive on Jan 26 1947.

Immediate cause of death: Uremia — Duration

Due to: Malignant Hypertension

Due to:

Other Conditions: Anemia

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Edmund L. Dudley M.D.
Address: Johns Hopkins Hospital Date signed 1-26-47

X

G47911 — G47911.1

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 93a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2007 Bryant Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 1
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 Bryant Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Louis Weintraub

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Pearl

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/22/1881 (1885)

8. AGE 65 Years | Months 8 | Days 13 | If less than one day hr. min.

9. Birthplace Russia (City, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER — 12. Name Harry Russia
13. Birthplace

MOTHER — 14. Maiden Name Freda Russia
15. Birthplace

16 (a) Informant Jack Weintraub
(b) Address 2012 Whittier Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-27-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philpot & Hamilton Aves

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

19 (a) (Date rec'd by registrar) JAN 27 1947 Registrar

VS Form

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** 1-25 1947 at 8:15 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 1/12 1947 to 1/25 1947.
and that I last saw h[illegible] alive on 1/25 1947.

Immediate cause of death: Uremic Manifestations & Failure — Duration: 1 day
Due to: Chronic Bronchitis (Bilateral) — 3 years
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23. Signature** Harry Lehman M.D.
Address 1912 Whittier Ave Date signed 1/26/47 M. D.

G47912

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

108

G47912 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2748 Winchester St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2748 Winchester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Louise Carolyn Boucsein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife: Carl A. Boucsein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1862

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 84 | 9 | 9 | hr. min. |

9. Birthplace Zweibruecken, Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jakob Bersch
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Schwartz
15. Birthplace Germany

16 (a) Informant Mrs. John J. West
(b) Address 2748 Winchester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 27, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miller Lawrence
(b) Address 4510 Liberty Heights Ave.

19 (a) (Date received by registrar) JAN 27 1947 Baltimore, Md.

vs 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1947, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 1947 to Jan 24 1947 and that I last saw her alive on Jan 24 1947

| Immediate cause of death | Duration |
|---|---|
| Lobar Pneumonia | 5 days |
| Due to Hypostatic | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: none
of autopsy: none

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? (Specify type of place)
(e) Means of injury ✓

23. Signature Miller A. Lawrence M. D.
Address 1219 Poplar Grove St. Date signed 1/26/47

X

G47913

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47913 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3730 Reisterstown Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3730 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Harry Kaffeman

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-1053

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Hinda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~1873~~ 1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| (74) 66 | | | hr. min. |

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business Tailor

FATHER
12. Name Unkown
13. Birthplace Poland

MOTHER
14. Maiden Name Unkown
15. Birthplace Poland

16 (a) Informant Gershon Kaffeman
(b) Address 3730 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 27 (month) (day) 47 (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Date rec'd by local registrar JAN 27 1947 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 1947; at 11.00 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 46 to Jany 26 1947 and that I last saw h[im] alive on Jan. 26 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral Arterio Sclerosis | |
| Uremia & Congestive Heart | |
| Due to Failure | 1yr. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Feaver
Address 11 E. Chase St. Date signed 1/28/47 M.D.

VS 150

G47914

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47914 Registered No. 122B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7312 Gwynn Falls Parkway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leah Cohen
3 (b) If veteran, name war
3 (c) Social Security Account No. 215-09-1516

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1882
8. AGE: Years 65 | Months | Days | If less than one day hr. min.
9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Simon Cohen
13. Birthplace Poland
MOTHER 14. Maiden Name Sarah Cohen
15. Birthplace Poland

16 (a) Informant Nathan Cohen
(b) Address 1101 Race St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 27/47 (month) (day) (year)
(c) Cemetery or crematory Sinai Memorial Park
Location Washington Blvd
18 (a) Funeral director Sol Kerbavson & Bro
(b) Address 1124 Hollins St
19 (a) JAN 27 1947 (Date rec'd by Registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-26- 1947, at 9:20 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 1-20 1947 to 1-26 1947, and that I last saw her alive on 1-26 1947.

| | Duration |
|---|---|
| Immediate cause of death Bronchopneumonia | |
| Pneumonitis | |
| Due to Tension Ulcer | |
| Due to Tension Pneumothorax | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Interstitial Pneumonitis
of autopsy: Confirmed, Tension Pneumothorax

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes state the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Elliott L. Weitzman
Address Sinai Hosp. Date 1-26-47 M.D.

120B

VS 150

G47915

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

937 ✓ Registered No. G47915

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3508 Fairview Ave.
(c) Hospital or institution: 15 58

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3508 Fairview Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** IDAHLIA E. GOLDER

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| None | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife George W. Golder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 1 | 13 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Henry Menslage
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Harris
15. Birthplace Talbot Co., Md.

16 (a) Informant Mr. Archibald Golder
(b) Address 3508 Fairview Ave.

17 (a) Burail (Burial, cremation, or removal) (b) Date thereof 1/27/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TECKNER
(b) Address Baltimore, Md.

19 (a) (Date rec'd by registrar) JAN 27 1947 (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23, 1947, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/25 1944 to 1/23 1947 and that I last saw h[illegible] alive on 1/23 1947.

| Immediate cause of death | Duration |
|---|---|
| Myocardial insufficiency | 2 wks. |
| Due to Arteriosclerosis | ? |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert A. Reiter M. D.
Address 340 W Rinaldo Ave Date signed 1/25/47

G47916

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1310

G47916 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Linden & Madeira Pl
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 202 N Monroe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Martha Jane Hill

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife: Clarence M. Hill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 5 | 14 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph B. Rea
13. Birthplace Baltimore

MOTHER
14. Maiden Name --
15. Birthplace --

16 (a) Informant Mrs. Paul James
(b) Address 806 Brunswick Rd., Essex 21, Md.

17 (a) Burial (b) Date thereof 1/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto. Md. Williams, Md.
19 (c) (b) Registrar
Filed by JAN 27 1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 24th 1947, at 4:40 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 1/14/1947 to 1/24/1947 and that I last saw her alive on 1/24/1947.
Immediate cause of death Heart failure — Duration
Due to Cardio-Vascular Renal Disease & decrepitude — 10 days
Due to Dilation -
Other Conditions Coronary disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature C. E. Gonzalez M. D.
Address Maryland Gen Hosp Date signed 1/28/47

G47917

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

G47917 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp. 15 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4023 Bateman Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** EDWARD Bernard EISENBRANDT

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | no |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21, 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 1 | 3 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business

FATHER
12. Name Henry Raphael Eisenbrandt
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Jeannette C. Wild
15. Birthplace Germany

16 (a) Informant Mrs. Garabed Heghinian
(b) Address 5528 Rusk Ave.

17 (a) Burial (b) Date thereof 1/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by Registrar) JAN 27 1947 (b) Wm. [illegible] M.D.

Cs 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1947, at 11 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/21/46 1946 to 1/24 1947, and that I last saw him alive on 1/24 1947.

Immediate cause of death ENCEPHALOMALACIA — Duration

Due to CEREBROVASCULAR ACCIDENT

Due to

Other Conditions EMPYEMA, LEFT CHEST
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: ENCEPALOMALACIA

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Gubnitsky

Address 3706 Rosedale Rd Date signed 1/26/47 (M. D.)

X

G47918

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13B

G47918 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 307 S. Fremont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Thelma Tobey Downes
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race N | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John Downes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/9/15

8. AGE: Years 31 | Months 4 | Days 15 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Henry Jobes
13. Birthplace Md

MOTHER
14. Maiden Name Elenor Clash
15. Birthplace md

16 (a) Informant Elenor Patterson
(b) Address 861 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 28-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James A Adams
(b) Address 1142 Westfield St

19 (a) (Date rec'd by registrar) (b) Registrar

VS JAN 27 1947 Huntington Williams, MD

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/24 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/20 1947 to 1/24 1947. and that I last saw h.r alive on 1/24/1947.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Tuberculosis | |
| Due to | 7 |
| Due to | |
| Other Conditions Malnutrition. Dehydration (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard Bomgardner M. D.
Address Provident Hospital Date signed 1/27/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47919

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

G47919 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 506 E. Chase St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 E. Chase St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anna Bracken

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife John E. Bracken

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 23, 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 1 | 2 | hr. min. |

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Home wife at

11. Industry or business Home

FATHER
12. Name Robert Wendt
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Mrs. Jamey R. Bracken
(b) Address 506 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29/47 (month) (day) (year)
(c) Cemetery or crematory Maryland Memorial Park
Location Edmondson Ave. & Conkling Sts.

18 (a) Funeral director 924 E. Eager St.
(b) Address

19 (a) (Signature) (b) Registrar

JAN 27 1947

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** January 25 1947, at 6:40 AM

**21.** I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1944 to Jan. 25 1947 and that I last saw h[illegible] alive on Jan. 24 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary Occlusion | 12 hours |
| Due to Hypertension | 10 yrs. |
| Due to Nephritis (Chronic) | 10 yrs. |
| Other Conditions Hemiplegia - since Sept. 1944 (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22. If death was due to external causes, fill in the following:**
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23. Signature** Charles I. Taggart M. D.
Address 3812 Greenmount Ave Signed 1/25/47

G47920

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

55E

Registered No. G47920

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hosp 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 E 20th (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mr Louis Nelson Scherf

3 (b) If veteran, name war: WW I
3 (c) Social Security Account No:

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife: ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 19, 1893

8. AGE: Years 53 | Months 4 | Days 7 | If less than one day: hr. 45 min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Blue Print reader
11. Industry or business Bethlehem Steel

FATHER
12. Name Charles F. Scherf
13. Birthplace Germany

MOTHER
14. Maiden Name Delia Staughton
15. Birthplace Ireland

16 (a) Informant Mr. Otto Scherf
(b) Address 3213 Homewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-47 (month) (day) (year)
(c) Cemetery or crematory Park Wood Cem.
Location City

18 (a) Funeral director Wiedefeld & Son
(b) Address Greenmount Ave & 22nd St.

19 (a) (Undertaker or other person) (b) Huntington Woods, Md

JAN 27 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-26 1947; at 1.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-24 1947 to 1-26 1947 and that I last saw him alive on 1-25 1947.

| Immediate cause of death | Duration |
|---|---|
| Peritonitis | |
| Due to Perforated ileum | |
| Due to | |
| Other Conditions Metastatic Carcinoma Liver — surgical? | |

(Include pregnancy within 3 months of death)
Date of operation 1-24-47
Major findings of operation: Tuberculous peritonitis
of autopsy: Peritonitis, perforated ileum, ca.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Conrad N. Kilpatrick, Jr. M. D.
Address Union Memorial Hosp Date signed 1-26-47

X

G17921
508381

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 47

Registered No. G17921

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5712 Rusk Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Miller

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Jennie R. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-26-85

8. AGE: Years 61 | Months 8 | Days 29 | If less than one day hr. min.

9. Birthplace md.
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Royal Transportation Co.

FATHER
12. Name Sarah Miller
13. Birthplace ?

MOTHER
14. Maiden Name Lona ?
15. Birthplace ?

16 (a) Informant Record.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 28 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore, Maryland

18 (a) Funeral director C. Langenthal & Bro.
(b) Address 1615-17 Eastern Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 25 1947 at 6 50 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19 1947, to Jan. 25 1947, and that I last saw h alive on Jan. 25 1947.

Immediate cause of death Resp. failure — Duration

Due to Carcinoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Hurst M.D.
Address Date signed 1-27-47

VS 190 JAN 27 1947 Huntington Baltimore Md

G47922

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G47922 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3424 Chestnut Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3424 Chestnut Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Joseph S. Ockendon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ethel J. Ockendon

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Dec 26, 1878

8. AGE: Years 68 | Months 1 | Days - | If less than one day ____ hr. ____ min.

9. Birthplace New York (town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Wm. F. Ockendon
13. Birthplace New York

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Ethel J. Ockendon
(b) Address 3424 Chestnut Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Chenoweth & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) ____ (Date received by registrar) (b) ____ Registrar

VS 191 JAN 27 1947

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** January 26 1947, 10:45 M

**21.** I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ____ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wallace J. Kelly M.D. Medical Examiner.
Date signed Jan 27, 1947

X

G47923

BC# G62343

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 157a

✓ G47923 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hospital 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 729 W. Fairmount
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

**3 (a) FULL NAME** ~~Alfred Mollquist Vedals~~ (Baby Boy Osborne)

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | Colored | |

6 (b) Name of husband or wife

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 11/16/46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 2 | 3 | ..... hr. ..... min. |

9. Birthplace ..... (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Roger Watts
13. Birthplace Pasadena, Md.

MOTHER
14. Maiden Name Mary Osborne
15. Birthplace Pasadena, Md.

16 (a) Informant Hospital Record
(b) Address University Hosp.

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)

(c) Cemetery or crematory
Local Johns Hopkins Medical Schoo JAN 24 1947

18 (a) Funeral director Commissioner of Health
(b) Address

JAN 27 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 8

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Jan 19, 1947, at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 25 1946, to Jan 19, 1947, and that I last saw h.i.m. alive on Jan 19 1947.

Immediate cause of death Respiratory Failure — Duration 2 mos.

Due to Hydrocephalus — (Since Birth)

Due to Spina Bifida & meningomyelocele

Other Conditions Bronchopneumonia

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W M H all

Address University Hosp. Date signed 1/21/47 M. D.

Balt. Md. X

G47924 BC# 568353 BALTIMORE CITY HEALTH DEPARTMENT ✓ G47924
Registered No.

# CERTIFICATE OF DEATH 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St.
(c) Hospital or institution: Union Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County 4
(c) City or town Baltimore 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 807 Glade Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Girl Sutter

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/14/47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 0 | 0 | 2 | hr. min. |

9. Birthplace Union Hospital
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Eugene Sutter
13. Birthplace Md

MOTHER
14. Maiden Name Pearl Ball
15. Birthplace Md

16 (a) Informant Pearl Sutter
(b) Address 807 Glade Ct.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo JAN 24 1947
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) JAN 27 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/16 1947 at 12:5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/14 1947 to 1/16 1947, and that I last saw h.C.R alive on 1/15 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardio-resp. failure | |
| Due to Prematurity | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Erwin R. Jennings, M.D. M.D.
Address Union Hosp. Date signed 1/16/47

VS 150

G47925 Late Certificate G-A153

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 161a

G47925

Registered No. 14747

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 719 George St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 0

17

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 719 George St. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Small

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | S |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/23/47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 0 | 0 | 0 | 0 hr. 10 min. |

9. Birthplace 719 George St. (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Willie Small
13. Birthplace Miss Lura S.C.

MOTHER
14. Maiden Name Ida Senior
15. Birthplace Miss Lura S.C.

16 (a) Informant Willie Small
(b) Address 719 George St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Loca Johns Hopkins Medical Schoo JAN 24 1947
18 (a) Funeral director Commissioner of Health
(b) Address
19 (Date rec'd by registrar) JAN 27 1947 Huntington for Williams, M.D.

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan 23 1947, at 2:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-23 1947 to 1-23 1947 and that I last saw him alive on 1-23 1947.

| Immediate cause of death | Duration |
|---|---|
| Edema of Asphyxiation, probable prolapse of cord, | |
| Due to Same. | |
| (Do not use abbreviations) | |
| Due to delivery, called Latta & No prenatal care. | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R B Leiby Watson M. D.
Address 501 Cherry Hill Rd. Date signed 1-23-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G47926

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13B

Registration No. G47926

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 657 N. Saratoga St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 657 N. Saratoga St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lillian Brantley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mc Commuce

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Febr 2 1907

8. AGE: Years 39 | Months 11 | Days 20 | If less than one day: hr. min.

9. Birthplace Smithfield, Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Decatur Crocker
13. Birthplace Virginia

MOTHER 14. Maiden Name Emma Hard
15. Birthplace Virginia

16 (a) Informant Georgia S. Edwards
(b) Address 657 N. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/25/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill ave.

19 (a) (Date rec'd by registrar) (b)

VS 150 JAN 27 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 1947 at 7 15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Jan 22 1947 and that I last saw [illegible] alive on Jan 22 1947.

Immediate cause of death: Pulmonary TB

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 6 mos

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 1/25/47

X

G47927 3 BC# D71492 BALTIMORE CITY HEALTH DEPARTMENT ✓ G47927
CERTIFICATE OF DEATH 160a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 940 Abbott Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby William Wayne Bruce

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Infant |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 25 46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 2 | 6 Weeks | hr. min. |

9. Birthplace Baltimore Md.
(Town/county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Athof H Bruce
13. Birthplace ? Virginia
MOTHER 14. Maiden Name Anna Belle Bruce
15. Birthplace ? Baltimore Md.
16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (b) Date thereof 1-27-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location York Road, Towson
18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul St.
19 JAN 27 1947 (b) Washington Williams, M.D.
(Date filed by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 25 1947 at 3 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1947 to Jan 25 1947 and that I last saw [redacted] alive on Jan 25 19—
Immediate cause of death | Duration
Fatal pre-maturity
Marasmus pre-natal cause
[redacted] Hemorrhage NJM
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
No operation performed
of autopsy: Negative Withdrawn Permission

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Howard Bruenechel M. D.
Address Johns Hopkins Hosp Date signed 1-25-47

VS 190 Fill'd Cf Submitted by Howard J. Venecio, M.D. X

G47928

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G47928 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St
(c) Hospital or institution:
Home for Incurables 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th St
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME**
Mrs Lucenia Simmonds Pierson

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | white | |

6 (b) Name of husband or wife Hamilton Ash Pierson
6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Dec. 1 1859

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 87 | 1 | 25 | 2:15 P.M. min. |

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Houses wife.
11. Industry or business

FATHER
12. Name Stephen Simmonds
13. Birthplace Germany

MOTHER
14. Maiden Name Josephine Hart
15. Birthplace Charleston South Carolina

16 (a) Informant E. Harriman Asst. Supt.
(b) Address 700 W. 40th St. Home for Incurables
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-47 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto. Md.
18 (a) Funeral director STEWART & [illegible] COMPANY
(b) Address (R. F. HOOVER Supt.) 100 W. NORTH AVENUE
19 (a) (Date rec'd by registrar) (b) [illegible]

VS 3 JAN 27 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Deceased JANUARY 26 1947, at 2:15 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from June 4th 1942 to January 26 1947, and that I last saw her alive on January 26 1947.

| Immediate cause of death | Duration |
|---|---|
| Bronchial Pneumonia | 3 days |
| Due to | |
| Due to | |
| Other Conditions Hypertension - Arteriosclerotic Cardio Vascular Disease (Include pregnancy within 3 months of death) | 20 years |
| Date of operation | PHYSICIAN |
| Major findings of operation | Underline the cause to which death should be charged statistically. |
| of autopsy | |

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thomas Conrad Wolf M. D.
[illegible] E. Chase St. Date signed 1/26/47
Baltimore 2, Md.

107

G47929

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

Registered No. G47929

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 142 W. Lanvale St.
(c) Hospital or institution: home
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County —
(c) City or town Balto. City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 142 W. Lanvale St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

**3 (a) FULL NAME** Nellie Stewart Hamilton

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 9. 1872

8. AGE: Years 74 | Months 2 | Days 16 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Stewart Hamilton
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Martin
15. Birthplace Balto. - Md.

16 (a) Informant Mrs. Roby M. Stoll (Cousin)
(b) Address 2838 St. Paul St. - City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-27-1947 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. - Md.

18 (a) Funeral director STEWART & HOWEN COMPANY
(b) Address (W. F. Howen Asst.) 100 N. North Avenue

19 (a) (Date rec'd) JAN 27 1947 (Registrar) Williams (b) Address Md. (c) Date signed 1/27/47

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25 1947, at 11 1/2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1941 to Jan. 25 1947, and that I last saw h[illegible] alive on Jan. 25 1947.

| Immediate cause of death | Duration |
|---|---|
| Hemiplegia - Apoplexy | 3 wks |
| Due to Arteriosclerosis | — |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(c) Means of injury

23. Signature Warren B. Adrian
Address 65 Eager St. Date signed 1/27/47

VS 8

G47930

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G47930

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 600 S. Oldham St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 D
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 600 S. Oldham (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Michael Nardone

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Maria Giuseppa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 24 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 4 | - | hr. min. |

9. Birthplace Celle S.Vito Italy
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Flavio Nardone
13. Birthplace Italy

MOTHER
14. Maiden Name Donata D'Aiuto
15. Birthplace Italy

16 (a) Informant Maria Giuseppa Nardone (Wife)
(b) Address 600 S. Oldham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 28 1947 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) (Date received by registrar) (b) By

JAN 27 1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 24 1947, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 1946 to Jan 24 1947 and that I last saw h alive on Jan 24 1947.

Immediate cause of death Cardio Vascular Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H J Faulkner M. D.
Address 100 N. Milton Date signed 1/24/47

X

G47931

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1467

Registered No. G47931

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Anthony WALTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | | | hr. min. |

9. Birthplace Groton Sc (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name Anthony Walton
13. Birthplace Groton Sc

MOTHER
14. Maiden Name Sallie ?
15. Birthplace unknown

16 (a) Informant Rosetta Walton
(b) Address 1513 Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 28, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Baltimore Md

18 (a) Funeral director Cleon O. Wilson
(b) Address 1700 Orleans St

19 (a) JAN 27 1947 Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 23 1947, at 12:20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of rectum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D. Medical Examiner.
Date signed 1/23/47

VS 151

G47932 BALTIMORE CITY HEALTH DEPARTMENT G47932

# CERTIFICATE OF DEATH 1947

Registered No.

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 535 Houser St.
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 535 Houser St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Henry Queen
3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-03-7106

4. Sex Male | 5. Color or race Col- | 6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Blanche Queen
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Unknown
8. AGE: Years 52 | Months — | Days — | If less than one day hr. min.
9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Jack Maria Queen
13. Birthplace Maryland

MOTHER
14. Maiden Name Alabama Johnson
15. Birthplace Maryland

16 (a) Informant Minnie Bates Butler
(b) Address 629 S. Paca St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) Jan 27 (day) (year) 47
(c) Cemetery or crematory Mt. Auburn Cemetery
Location Balto. Md.

18 (a) Funeral director Walter B. Griggs
(b) Address 139 W. Hamburg Street

19 (a) (Date rec'd by registrar) (b) Huntington, Williamsport, Md.

VS JAN 27 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1947, at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1947 to Jan 23 1947, and that I last saw him alive on Jan 23 1947.

| | Duration |
|---|---|
| Immediate cause of death Acute Cardiac Dilatation | 3 days |
| Due to Chr. Cardio-Vascular Disease | Unknown |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John W. Hagner M. D.
Address 507 W. Hamburg St. Date signed 1/28/47

X

G47933

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G47933
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2369 McCulloh St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2369 McCulloh St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** NELLIE F. YOUNG

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Colored | Married |

6 (b) Name of husband or wife William H. Young
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1897

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 49 | 7 | 17 | hr. min. |

9. Birthplace Wilmington, N. C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Foreman
13. Birthplace N. C.

MOTHER
14. Maiden Name Ella Daniel
15. Birthplace N. C.

16 (a) Informant Mr. William H. Young
(b) Address 2369 McCulloh St.

17 (a) Burial (b) Date thereof 1-28-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date received by Registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 24 1947, at 7P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22-47 to 1-24-1947 and that I last saw her alive on 1-24-1947 when

| Immediate cause of death | Duration |
|---|---|
| Diabetic Coma | |
| Diabetes Mellitus | ? |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H P Stugher M. D.
Address 825 N. Fremont Date signed 1-27-47

1-27-1947 Twilley Williams

VS 150

G47934 BC# G68388

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 107

G47934 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE & JOHN
(c) Hospital or institution: WOMENS HOSPITAL 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MARYLAND (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 14 W. MOUNT VERNON PLACE
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BABY BEEHLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| MALE | WHITE | SINGLE |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN 19, 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 6 | hr. min. |

9. Birthplace WOMENS HOSPITAL BALTIMORE (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name WILLIAM H. BEEHLER JR.
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name ELIZABETH CAREY BAXTER
15. Birthplace BALTIMORE, MD

16 (a) Informant HOSPITAL RECORDS
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/27/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) 805 N. Calvert St.

JAN 27 1947 (Date rec'd by registrar)

(b) [signature] Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 25 1947, at 3:32 P M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN. 19 1947, to JAN. 25 1947, and that I last saw him alive on JAN. 25 1947.

| Immediate cause of death | Duration |
|---|---|
| RESPIRATORY FAILURE | |
| Due to PNEUMONIA | 3 DA. |
| Due to ATELECTASIS, PULMONARY | 6 DA. |
| Other Conditions | over |

(Include pregnancy within 3 months of death)

Date of operation BRONCHOSCOPY 1-24-47

Major findings of operation: PNEUMONIA, ATELECTASIS, BILATERAL

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James H. McCook Jr. M. D.
Address Women's Hosp. Balto. Date signed 1/28/47

VS 3

X

Bird Certificate
G47935 Y.69083

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

G47935
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Ave
(c) Hospital or institution:
St. Agnes Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 Allendale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Gray Little (Francis C. Little)
3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | S. |

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1/25/1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 1 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles H. Little
13. Birthplace ~~N.E.~~ Balto. Md.

MOTHER
14. Maiden Name Gemma ~~Rossini~~ Lorette
15. Birthplace N. Y.

16 (a) Informant Hosp. Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-27-1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St

19 (a) JAN 27 1947 (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/26 1947. at 7:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/25 1947 to 1/26 1947. and that I last saw h[illegible] alive on 1/26 1947.

| Immediate cause of death | Duration |
|---|---|
| Prematurity | |
| Due to Cause unknown | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stuart D. Rizika M. D.
St. Agnes Hosp. Date signed 1/26/47

VS 150

G47936

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

Registered No. G47936

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 yrs 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 666 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ruth Johnson

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Fe | N | Single |

6 (b) Name of husband or wife [redacted]
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/3/13

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 33 | 11 | 20 | hr. min. |

9. Birthplace Baltimore City (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Charles Johnson
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ella [illegible]
15. Birthplace Balto. Md.

16 (a) Informant Ella Johnson
(b) Address 767 W. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 25, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 3229 Rhoades St.

19 (a) JAN 27 1947 (Date received by registrar) (b) [illegible] Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/23 1947, at 10:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/23 1947, to 1/24 1947, 10 A.M.; and that I last saw her alive on 1/23 1947

| Immediate cause of death | Duration |
|---|---|
| Diabetic Acidosis | |
| Due to Diabetes Mellitus | 12 Yrs? |
| Due to | |
| Other Conditions Malnutrition | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Bangeles
Address Thomas Hospital Date signed 1/25/47 (M. D.)

VS 150

G47937

CHK-84558

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3- 2- 20- 26

(e) Length of stay in Baltimore (yrs., mos., or days) 3- 4- 20-

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Not Known (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

**3 (a) FULL NAME** Floyd Tinsley

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Widower |

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6-1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 3 | 10 | hr. min. |

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Henry Tinsley

13. Birthplace ?

MOTHER

14. Maiden Name Susan

15. Birthplace ?

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 23 1947 (month) (day) (year)

(c) Cemetery or crematory W. H. Milburn Asn.

Location

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 W. Lafayette St.

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 27 1947

V S 150

## MEDICAL CERTIFICATION

P

20. DATE OF DEATH January 16 19 47, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 26 19 43, to Jan. 16 19 47, and that I last saw him alive on Jan. 16 19 47.

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia | 2 days |
| Bilateral | |
| Due to | |
| Due to | |
| Other Conditions Hypertension Arteriosclerosis | yrs |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.

Balt. City Hosp. Date signed 1/23/47

G47938

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93E

G47938
Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5016 Catopha Rd.
(If rural give location)
(e) Citizen of foreign country? Catopha (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas L Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 21 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 9 | 4 | hr. min. |

9. Birthplace Maryland
(Town, county and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name James J Murphy
13. Birthplace Md

MOTHER
14. Maiden Name Alma Nebbert
15. Birthplace Md

16 (a) Informant Mrs Thos L Murphy
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-47 (month) (day) (year)
Druid Ridge
(c) Cemetery or crematory
Location Balto Md

18 (a) Funeral director Geo A Farley
(b) Address Baltimore Md

JAN 27 1947 (Date filed by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-25- 1947, at 9 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute congestive heart failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 1/24/47

VS 151

G47939

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47939 Registered No. 11

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1718 W Lombard
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1718 W Lombard (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Helen M Poindale

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Aloysius H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 6 1875

8. AGE: Years 71 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Patrick Downey

13. Birthplace Ireland

MOTHER 14. Maiden Name Margaret Ryley

15. Birthplace Ireland

16 (a) Informant Leo Poindale

(b) Address Catonsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-27-47 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore Md

18 (a) Funeral director George E Staley

(b) Address Fulton & Fayette

19 (a) JAN 27 1947 (b) Registered by registrar Livingston Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1947 at 8 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1945 to Jan 23 1947 and that I last saw h[illegible] alive on Jan 23 1947

Immediate cause of death Respiratory failure — Duration

Due to Acute Cardio Vascular Disease.

Due to

Other Conditions Gastro-Enteritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Scognetta M. D.

Address 1729 W Lombard St Date signed 1/25/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please, write the causes of death clearly and legibly.

G47940 G47940

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 51B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1741 N Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Joseph H. Parr

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-3730

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife Mary B. Knox
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 5 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 2 | 19 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Const. Engr Co

FATHER
12. Name Henry Parr.
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Louise Ulrich
15. Birthplace Baltimore Md

16 (a) Informant Wife
(b) Address 1741 N Bond St

17 (a) Burial (b) Date thereof 7/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Clarence E. Hoffman
(b) Address 1639 N Broadway

JAN 27 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 24 Jan 1947 at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 13 Jan 1947 to 24 Jan 1947 and that I last saw h.. alive on 24 Jan 1947

Immediate cause of death Respiratory failure — Duration

Due to bronchopneumonia & pulmonary edema

Due to Cachexia

Other Conditions Metastatic carcinoma of prostate

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: as above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard M. Jordan M. D.
Address Sinai Hospital Date signed Jan 24 1947

VS 150

G47941

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

108

G47941 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3400 Toone St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Bertha Ehrenfeld

3 (b) If veteran, name war: —

3 (c) Social Security Account No. —

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21-1873

8. AGE: Years 73 | Months 7 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Mr. James Goodwin
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Eliza Bomber
15. Birthplace Baltimore Md.

16 (a) Informant (Son) Mr. Harold Ehrenfeld.
(b) Address 710 Grindald Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location north ave & Rose St

18 (a) Funeral director Salvena P. Hoffman
(b) Address 1639 N Broadway

19 (a) 27 1947 (Date rec'd by registrar) Thos. Williams M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/26/47 19 at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/26/47 19 to 1/26/47 19, and that I last saw h alive on 1/26/47 19.

| Immediate cause of death | Duration |
|---|---|
| a Pneumonia | |
| b Heart failure | |
| Due to | |
| Due to | |
| Other Conditions | |
| | sweet |

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy: none

**PHYSICIAN.** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph D'Antonio M. D.
Address Church Home Hosp Date signed 1/27/47

Jos. D'Antonio, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47942 — BALTIMORE CITY HEALTH DEPARTMENT — G47942

# CERTIFICATE OF DEATH 1937

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1431 Halbrook Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1431 Halbrook (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Martin L. Dunphy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Catherine Dunphy (Maiden name) | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: abt 55 | Months | Days | If less than one day: hr. min.

9. Birthplace: Ireland (Town, county, and state)

10. Usual Occupation: Carpenter

11. Industry or business: Bell's Transit

FATHER — 12. Name: ? Dunphy.
13. Birthplace: Ireland

MOTHER — 14. Maiden Name: Do not know
15. Birthplace: Do not know

16 (a) Informant: Mrs Cath Dunphy
(b) Address: 1431 Halbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1/29/37 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: Old Section Lot

18 (a) Funeral director: J. Foley Eyre
(b) Address: 1318 Eight St.

19 (a) JAN 27 1937 (b) [illegible] Williams, Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/26 1937 at 7 00 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1936 to 1/26 1937 and that I last saw it alive on 2/3 1936

Immediate cause of death: Cerebral Hemorrhage — Duration: 3 days

Due to: Coronary Sclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Sue Smith

Address: 1223 E Northern Date signed: M. 1/26/37 D.

X

G47943

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47943 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1113 Myrtle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 das

**2. USUAL RESIDENCE OF DECEASED:**
(a) State (b) County Lancaster
(c) City or town Va.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Pinn

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

4. Sex M

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Widowed.

6 (b) Name of husband or wife Elizabeth Pinn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-4-1856

8. AGE: Years 90 | Months 10 | Days 21 | If less than one day 22 hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John Pinn

13. Birthplace Virginia.

MOTHER 14. Maiden Name —

15. Birthplace —

16 (a) Informant Roland Pinn

(b) Address 1113 Myrtle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/47 (month) (day) (year)

(c) Cemetery or crematory Lancaster

Location Lancaster Co. Va

18 (a) Funeral director Geo. D. Nelson

(b) Address 1303 Pennsylvania Ave

JAN 27 1947 (Date rec'd by Registrar) [illegible] Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1947 at 9.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1947 to Jan 26 1947 and that I last saw him alive on Jan 25 1947.

| Immediate cause of death | Duration |
|---|---|
| Congestive Heart Failure | ? |
| Due to Arteriosclerotic Heart disease | |
| Due to | |
| Other Conditions Senility | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Herbert H. Hundley M.D.
Address 2024 Madison Ave Date signed 1/27/47

VS 150

G47944

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 30c

G47944 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4506 Frederick Avenue
(c) Hospital or institution:
Colonial Nursing & Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 months
(e) Length of stay in Baltimore (yrs., mos., or days) 69 years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4506 Frederick Road
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** George Schneydter

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | No |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Elizabeth Schneydter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25th, 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 6 | 6 | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Confectioner
11. Industry or business

FATHER
12. Name George Schneydter
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Lucce Schneydter
(b) Address 3121 E. Monument Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location 3801 Frederick Road

18 (a) Funeral director Frederick D. Miller, Inc.
(b) Address 3019 E. Monument Street

19 (a) (Date rec'd by registrar) (b) Registrar

VS JAN 27 1947 Filed for Publication, Md.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 25th 1947, at 10.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 28 1946 to Jan 25 1947 and that I last saw h[illegible] alive on Jan 28 1947.

Immediate cause of death Bronchial Pneumonia — Duration 1 wk.

Due to

Due to

Other Conditions C.N.S. Syphilis Chr. Tbc.
(Include pregnancy within 3 months of death)

Date of operation No

Major findings of operation: No

of autopsy: No

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1933 W. Belt St Date signed 1/26/47

X

G47945

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G47945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 315 Dolphin Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-9
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 315 Dolphin Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** WARREN WINFIELD HASLETT

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 220-24-9160

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Naomi Lydia Haslett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1869

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 1 | 20 | hr. min. |

9. Birthplace Washington D. C.
(Town, county, and state)

10. Usual Occupation Interior Decorator

11. Industry or business

FATHER
12. Name Robert Haslett
13. Birthplace Washington, D. C.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Warren G. Haslett
(b) Address 2904 Harview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) JAN 27 19 [illegible] Registrar

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/26/47 19 at 1:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Renal

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Weir M.D.
Medical Examiner.
Date signed 1/26/47

G47946

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G47946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2720 St. Paul St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town 2720 St. Paul St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** CLARA M. WALKER

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| - | - |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Llewellyn Walker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1869

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 11 | 1 2 | hr. min. |

9. Birthplace Hagerstown, Md.
(Town, county, and state)
10. Usual Occupation -
11. Industry or business -

FATHER
12. Name Ephraim Funk
13. Birthplace Hagerstown, Md.

MOTHER
14. Maiden Name Rebecca Knode
15. Birthplace Hagerstown, Md.

16 (a) Informant Mrs. H. Tirant Hodges
(b) Address 2720 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Williams, Md. Registrar

VS 1Sd JAN 27 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 25, 1947; at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24, 1947 to Jan 25 1947. and that I last saw her alive on Jan. 25, 1947.

| | Duration |
|---|---|
| Immediate cause of death Coronary Thrombosis | Few hours |
| Due to Hypertensive Cardio-Vascular Disease | 5 years |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation -
Major findings of operation: -
of autopsy: -

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide -
(b) Date of occurrence - at M
(c) Where did injury occur? - (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? - (Specify type of place) While at work? -
(e) Means of injury

23. Signature Wm. M. Baumebaker M. D.
Address 2740 St. Paul St. Date signed Jan 27, 47.

X

G47947

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83B

G47947
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Linden Ave & Madison St
(c) Hospital or institution:
MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1837 Idanford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** CHARLES RAYMONDI (Raimondi)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 19 1870

8. AGE: Years 76 Months 10 Days 6 If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name Petro Raimondi
13. Birthplace Italy

MOTHER
14. Maiden Name Frances Citrano
15. Birthplace Italy

16 (a) Informant Jennie Lipsimano
(b) Address 1834 N Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 28th 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location: Belair Road

18 (a) Funeral director Leo G. Lewis
(b) Address 1201-03 N Patterson Park Ave

19 (a) Jan 27 1947 (date received by local registrar) (b) Williamsport (Md.) (registration district) 2 (registration district number)

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 1/25 1947, at 7.50 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from 1/19 1947, to 1/25 1947, and that I last saw him alive on 1/25 1947.

Immediate cause of death CEREBRAL ARTERIOSCLEROSIS AND THROMBOSIS — Duration 6 DAYS
TERMINAL BRONCHOPNEUMONIA
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23.** Signature Charles W. Stewart, Jr. M. D.
Address Md. Gen. Hosp. Date signed 1/26/47

X

G47948 F

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G47948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3421 Paton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3421 Paton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** John B. Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1877

8. AGE: Years 70 | Months - | Days 15 | If less than one day hr. min.

9. Birthplace Alabama (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name John Cooper
13. Birthplace Alabama

MOTHER 14. Maiden Name Katherine Cooper
15. Birthplace

16 (a) Informant Mrs. Bessie Campbell
(b) Address 5209 Denmead Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 25, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lee F. Holland
(b) Address 1651 Druid Hill Ave

19 Filed Jan 27 1947 [illegible] Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Jan 25 1947, at M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to 19 , and that I last saw [illegible] alive on 1947.

Immediate cause of death Myocarditis — Duration 1 year

Due to Arteriosclerosis

Due to Senility

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23.** Signature Clarence J. Trader M.D.
Address 1776 Park Ave Date signed Jan 27 1947

VS 150

G47949

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G47949

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William H. Kuhn

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 218-03-1387

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1893

8. AGE: Years 53 | Months 4 | Days 19 | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Veteran (Pensioner)

FATHER
12. Name Geo. A. Kuhn
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Gertrude Huber
15. Birthplace Balto. Md.

16 (a) Informant Mrs Gertrude Kuhn (Widow)
(b) Address 1109 Hanover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29, 1947 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location A.G. Co., Md.

18 (a) Funeral director G. Howard Evans
(b) Address 1400 St. Charles St., Balto 39 Md.

19 (a) (Date received by Registrar) (b) JAN 27 1947 Registrar

VS 151

Huntingtown, Williams, Md.

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 1-26- 1947 at 3 P.M.

**21.** I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature George A. Merrill M.D.
Medical Examiner.
Date signed 1/27/47

G47950

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

131a

Registered No. G47950

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 533 Sanford Pl
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 533 Sanford Pl.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Emma Gertrude Royal

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/13/1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | - | 11 | hr. min. |

9. Birthplace Wilmington N.C.
(Town, county, and state)

10. Usual Occupation Maid

11. Industry or business

| | |
|---|---|
| FATHER 12. Name | Milton Royal |
| FATHER 13. Birthplace | Norfolk Va |
| MOTHER 14. Maiden Name | Jane Swayne |
| MOTHER 15. Birthplace | Wilmington N.C |

16 (a) Informant Princeton Royal
(b) Address 533 Sanford Pl.

17 (a) Burial (b) Date thereof Jan 28 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Balto, Md.

18 (a) Funeral director George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (b) Registrar
(Date rec'd by registrar)
JAN 28 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/24 1947, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/7 1946 to 1/24 1947 and that I last saw h alive on 1/24 19

Immediate cause of death: Hypertensive cardio-renal disease — Duration: 2 yrs

Due to

Due to

Other Conditions: mitral insufficiency
fibroma uteri
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rayner Browne M. D.

Address 1100 E. Madison St Date signed 1/27

Rayner Browne X

G47951

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 102

G47951 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: Mt Baltimore General Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2914 Glendale Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Florence M. Eberight

3 (b) If veteran, name war —
3 (c) Social Security Account No. 705-10-0106

4 Sex: Female
5 Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Albert Eberight
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11-1901

8. AGE: Years 45 Months 11 Days 17 If less than one day hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Clerk
11. Industry or business: B & O Railroad Co.

FATHER
12. Name: Jonas E. L. Ruby
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Annie M. Hare
15. Birthplace: Maryland

16 (a) Informant: Albert Eberight
(b) Address: 2914 Glendale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan 28-1947 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Baltimore Co. Md.

18 (a) Funeral director: Burgee Funeral Home
(b) Address: 3221 Falls Road

19 (a) [illegible] Williams [illegible] (Registrar)

JAN 27 1947

VS 150

**MEDICAL CERTIFICATION** A.

20. DATE OF DEATH 1/25/ 1947, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/20/ 1947 to 1/25 1947 and that I last saw h[illegible] alive on 1/25 1947.

Immediate cause of death: surgical shock — Duration
Due to: myocardial failure — over
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation 1/25/47
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Joseph Johns M. D.
Address: West Baltimore Md. Date signed 1/27/47

X

EDITH E. COOPER

G47952

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G47952

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Eaton & Hilleans Aves
(c) Hospital or institution:
St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 59 years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore - 11
(If outside city or town limits, write RURAL and give town)
(d) Street No. 914 N 37th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Edith E. Cooper

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27-1866

8. AGE: Years 80 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Wm J. Cooper
13. Birthplace Md

MOTHER
14. Maiden Name Mary E. Williams
15. Birthplace Md

16 (a) Informant Mrs Winfield Lovell
(b) Address 914 N. 37th Street

17 (a) Burial (b) Date thereof Jan 29-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or Crematory Lorraine Park
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 333 Falls Road Hunt Valley Md

19 (a) Date of this registration (b) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/26 1947, at 7:45 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 1/18 1947 to 1/26 1947, and that I last saw h[illegible] alive on 1/26 1947.

Immediate cause of death
Cardiac Failure — Duration

Due to Arteriosclerotic Heart Disease

Due to

Other Condition Auricular Fibrillation
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry W. Hollies M. D.
Address St. Agnes Hosp Date signed 1-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47953 √83a

Registered No. G47953

G47953

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5318 Park Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5318 Park Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Agnes Cremen

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 5 | 26 | 27 hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert Cremen
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Wall
15. Birthplace Ireland

16 (a) Informant Mrs. Robert Cremen
(b) Address 5318 Park Hgts. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 28/47 (month) (day) (year)
(c) Cemetery or crematory St. Charles Cemetery
Location Pikesville, Md.

18 (a) Funeral director C. Vernon Zimmerman
(b) Address 4611 Park Hgts. Ave.

(a) JAN 27 1947 Thurlington Williams M.D. Registrar
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 24, 1947, at 5 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24 1947 to Jan 24 1947 and that I last saw her alive on Jan 24 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration 1/24/47
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lloyd Bullet M. D.
Address 4303 Park Hgts. Date signed

V S 150

X

G47954 BALTIMORE CITY HEALTH DEPARTMENT G47954
Registered No.

# CERTIFICATE OF DEATH 52a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or institution (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mo. 2 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3210 Batavia Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs. Louise S. Mitchell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: George H.

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 13-1875

8. AGE: Years 72 | Months 9 | Days 19 | If less than one day hr. min.

9. Birthplace Williamsport, Pa.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name William Sauer
13. Birthplace Pa.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mr. George H. Mitchell
(b) Address 3210 Batavia Avenue

17 (a) Burial (b) Date thereof 1/29/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard Luck
(b) Address 530 S Harford Road -
(c) Date received Williamsport, Md.

JAN 27 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-25 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-4 1946 to 1-25 1947, and that I last saw h[illegible] alive on 1-25 1947

Immediate cause of death [illegible] Pulmonary Edema
Carcinoma of Kidney
Edema

| | Duration |
|---|---|
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
Autopsy: Pathological

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. B. Harby, M.D.
M. D.
Address Univ. Hosp. Date signed 1-25-47

VS 150

X

G47955

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47955 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5322 Dogwood Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph O. Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Alice Wade Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-18-1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 5 | 6 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Joseph E. Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Kramm
15. Birthplace Md.

16 (a) Informant Mrs. Alice W. Smith
(b) Address 5322 Dogwood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 28/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Harry N. Fritzke
(b) Address 900 Edmondson Ave.

19 (a) JAN 27 1947 (Date rec'd by registrar) Hugh A. Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/24/47 19 at 10:? M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 19 47 to 1/24 19 47.
and that I last saw him alive on 1/24 19 47.

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure | |
| Due to Hemorrhage | |
| Due to Gangrene of L. foot | |
| Due to Arteriosclerosis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 1/22/47
Major findings of operation Amputation Left Leg
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Mintz
Address St. Agnes Date signed 1/27/47

VS 150

G47956

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G47956 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1607 W. Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** George Reninger

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1863

8. AGE: Years 83 | Months 10 | Days 20 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Pater Reninger
13. Birthplace Germany

MOTHER
14. Maiden Name Ottilia Doppler
15. Birthplace Germany

16 (a) Informant Miss Mary Reninger
(b) Address 1607 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Rd.

18 (a) Funeral director Harry H. Lutzke
(b) Address 4101 Edmondson Ave

19 (a) JAN 27 1947 (b) (Date received by Registrar) Registrar

Huntington Williams, M.D.

V S 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 25 1947, at 12:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1947 to Jan 25 1947 and that I last saw h.e.w.m alive on Jan 24 1947

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | 1 Day |
| Due to Generalarteriosclerosis | 5 years |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thelma F. Williams M.D.
Address 6 E. Biddle St. Date signed 1/27/47 M. D.

X

G47957 Hugelheim

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

107

Registered No. G47957

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 804 N. Augusta Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 804 N. Augusta Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Amelia Hugelheim ✓

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Late August Hugelheim
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 5 | 11 | hr. min. |

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Charles Heinz
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Mrs. Marie Johnson
(b) Address 804 N. Augusta Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Jan 29/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd.

18 (a) Funeral director Henry H. Withe
(b) Address 4101 Edmondson Ave

19 (a) JAN 27 1947 [illegible] Williams

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 1947, at 1130 P. M

21. I certify that death occurred on the date above stated; that I attended. deceased from Jan 7 1937 to January 25 1947 and that I last saw [illegible] alive on 1/25 1947

Immediate cause of death
Broncho Pneumonia and Exhaustion
Due to Not definite
Due to
Other Conditions Chronic Arthritis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
7 Days
For about 14 yrs.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Amelia E. Link M. D.
Address 2211 E Lake Ave Date signed 1/26/47

VS 150

G47958 184

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 469

Registered No. G47958

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 908 Belmont Ct.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

**3 (a) FULL NAME** Lena Bradley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife —

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 10-25-73

8. AGE: Years 74 | Months 3 | Days - | If less than one day .....hr. .....min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation.....

11. Industry or business.....

FATHER — 12. Name Anton Freddy
13. Birthplace Germany.

MOTHER — 14. Maiden Name Mary Bruns.
15. Birthplace Germany

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/47 (month) (day) (year)

(c) Cemetery or crematory Oakland Cem.
Location.....

18 (a) Funeral director Charles P Towell
(b) Address 2427 E Lanvale cor Wolfe

19 JAN 27 1947 [illegible] Registrar

VS 130

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 25 1947 at 2 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 13 1947 to Jan 25 1947 and that I last saw her alive on Jan. 25 1947

Immediate cause of death Cancer of lung
of pancreas — Duration 6-12 mo

Due to.....

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at .....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Douglas P. Towell

Address Johns Hopkins Hosp. Date signed 1-25 1947

X

G17959

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48B

Registered No. G17959

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2300 Lanvale Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Swift

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W.

6 (a) ~~Single~~, ~~married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband or ~~wife~~: Dean M. Swift

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 8 | 6 | hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Frank L. Knell
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Kegler
15. Birthplace Germany

16 (a) Informant Catherine R. McKenna
(b) Address 334 S. Augusta Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1/29/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Fahey & Sons
(b) Address 1827 W. North Ave.

JAN 28 1947 (Date rec'd by Registrar) [illegible] Williams M.D. (Signature of Registrar)

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** January 26 1947 at 11:45 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 1-20-47 19 to 1-26 1947 and that I last saw her alive on 1-26 19 47.

Immediate cause of death: Cardio-respiratory failure — Duration

Due to: Paralytic ileus — Duration

Due to: Post operative for Adeno-carcinoma of duodenum — Duration

Other Conditions: Uterus — Duration

(Include pregnancy within 3 months of death)

Date of operation Jan. 21, 1947

Major findings of operation: Adeno-carcinoma of duodenum & liver

of autopsy Paralytic ileus

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23.** Signature Robert E. Fowler M. D.

Address Bon Secours Hosp., Balto. Date signed 1-26-47

G47960

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G47960

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 Mura St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Clara A. Henderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Wm G. Henderson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr): Sept 24th 1874

8. AGE: Years 67 | Months 4 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace: Balt. Md. (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Frederick Burkhardt
13. Birthplace: Switzerland

MOTHER
14. Maiden Name: Lucinda Bahn
15. Birthplace: Pa

16 (a) Informant: John D. Hoffman
(b) Address: 709 Mura St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/30/47 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Balto. Md.

18 (a) Funeral director: Wm Cook Inc
(b) Address: 1217 E. Pratt St

JAN 28 1947 (Date rec'd by registrar) (By) Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Jan 27th 1947, at 9 07 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1947 to Jan 27 1947, and that I last saw her alive on Jan 27 1947.

Immediate cause of death: General Arterio Sclerosis / Chronic Myocarditis — Duration: 5 yrs. / 5 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Milton F. Solomon
Address 129 S Broadway Date signed 1/27/47

VS 150

G47961 Claimed from City Hosp. 43247

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47961 Registered No.

CWK-107041

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. High Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
John Rosendahl

3 (b) If veteran, name war

3 (c) Social Security Account No. 52-0547-414

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 28-1896

8. AGE: Years 50 | Months 6 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Sweden
(Town, county, and state)

10. Usual Occupation

11. Industry or business Atlas Steel Co

FATHER
12. Name Nick Rosendahl
13. Birthplace Sweden

MOTHER
14. Maiden Name Ann Anderson
15. Birthplace Sweden

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 1/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location A.A. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

JAN 28 1947 (Date received by local registrar) (Signature of local registrar) William Holt Registrar

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 17 1947, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 23 1946, to Jan. 17 1947, and that I last saw h. im alive on Jan. 17 1947.

| | Duration |
|---|---|
| Immediate cause of death Coronary Occlusion | |
| Due to Subacute Bacterial Endocarditis - Aortic Valve | |
| Due to ? Rheumatic H. Disease. | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert R. Fasbe M. D.
Address Balto City Hosps Date signed 1-23-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

X

G47962

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13B

G47962 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2728 Pelham Ave
(c) Hospital or institution: 8

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2728 Pelham Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas B. S. Fowler Sr.

3 (b) If veteran, name war No. | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Mary L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28 1876

8. AGE: Years 70 | Months 5 | Days 29 | If less than one day hr. min.

9. Birthplace Wash. D.C. (Town, county and state)

10. Usual Occupation Retired-Car Inspector
11. Industry or business P. R.R.

FATHER 12. Name Henry C Fowler
13. Birthplace Wash D.C.

MOTHER 14. Maiden Name Mollie Queen
15. Birthplace Md

16 (a) Informant Mary L. Fowler
(b) Address 2728 Pelham Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/47 (month) (day) (year)
(c) Cemetery or crematory Woodland Rd.
Location Parkville

18 (a) Funeral director Wm. Cook Inc
(b) Address 1217 St Paul St.

JAN 28 1947 (Date rec'd by Registrar) (b) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 27 1947, at 12 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1940 to Jan 27 47 and that I last saw him alive on 19

Immediate cause of death Jan 28
Pulmonary Edema

Due to

Due to Chronic Emphysema 7 years.

Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jos L. Valentine M. D.
Address 1732 Mc Mechen Date signed Jan 27-47

X

G47963

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47963 Registered No. 136

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1735 Abbottston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1735 Abbottston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John E Bennett

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 12 1888

8. AGE: Years 58 | Months 3 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Cloverland Dairy

FATHER
12. Name Lewis T Bennett
13. Birthplace Frederick Md

MOTHER
14. Maiden Name Emma Silence
15. Birthplace Baltimore Md

16 (a) Informant Anna E Bevans
(b) Address 1735 Abbottston St

17. Burial (Burial, cremation, or removal) (b) Date thereof 1/29/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilhelm Lohr Inc
(b) Address 1217 E Lexington St

19. (a) Date received by registrar JAN 28 1947 (b) Registrar Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Jan 26 1947, at 5 58 M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Oct 1946, to Jan 26 1947, and that I last saw h[illegible] alive on Jan 26 1947

Immediate cause of death: Far Advanced Pulmonary Tuberculosis — Duration: 6 months

Due to:

Due to: Coronary Thrombosis — Duration: few days

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23.** Signature Alex A Weinstock M. D.
Address 4603 Belvedere Ave Date signed 1/27/47

G47964

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G47964
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Henry Redwood St.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1821 Bolton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Heinlein

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-0085

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Daisy Heinlein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Telephone man

11. Industry or business C & P Telephone Co

FATHER
12. Name George Heinlein
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary (Unknown)
15. Birthplace Balto. Md.

16 (a) Informant George H. Heinlein Jr.
(b) Address 2025 Rayner Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/30/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

JAN 28 1947 (Date Rec'd by Registrar) (b) Williams M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1947, at 8:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-27 1947 to 1-27 1947 and that I last saw him alive on 1-27 1947.

Immediate cause of death Cardiac failure — Duration

Due to Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Hawkins M.D. M. D.
Address Univ. Hosp. Date signed 1-27-47

Q47965

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. Q47965 — 1318

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1814 Belt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 54
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 Belt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William O Willey

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-2710

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ella Willey

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 29 1888

8. AGE: Years 58 | Months 1 | Days 26 | If less than one day: hr. min.

9. Birthplace: Cambridge Md (Town, county and state)

10. Usual Occupation: Carpenter

11. Industry or business

FATHER — 12. Name: Charles Willey

13. Birthplace: Cambridge Md

MOTHER — 14. Maiden Name: Nannie Willey

15. Birthplace: Cambridge Md

16 (a) Informant: Ella Willey

(b) Address: 1814 Belt St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1/29/47 (month) (day) (year)

(c) Cemetery or crematory: Glen Haven

Location: Glen Burnie Md

18 (a) Funeral director: Wilson Col Son

(b) Address: 1217 E Fayette St

19. JAN 28 1947 (Date received by Registrar) (Signature of Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 25 1947, 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2 1946, to 1/25 1947 and that I last saw h alive on 1/24 1947

| Immediate cause of death | Duration |
|---|---|
| Acute Dilation of Heart | 3 days |
| Due to Pernicious Nephritis | Indefinite |
| Other Conditions None | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R B Campbell M. D.

Address 1644 Hanover Date signed 1/27/47

VS 150

G47966

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47966 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address REDWOOD & GREENE STS.
(c) Hospital or institution: UNIVERSITY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 6 DAYS

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County CARROLL
(c) City or town WESTMINSTER (If outside city or town limits, write RURAL and give town)
(d) Street No. 32 BOND ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME DAISEY UHRIG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, (widowed) or divorced

6 (b) Name of husband or wife John H. | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 13, 1871

8. AGE: Years 75 | Months 3 | Days 11 | If less than one day 14 hr. min.

9. Birthplace OHIO (Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER
12. Name ELWOOD HUSSEY
13. Birthplace N.C.

MOTHER
14. Maiden Name ELIZ. BURDETTE
15. Birthplace Kentucky

16 (a) Informant Ruth Shreeve Uhrig
(b) Address Westminster

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/28/47 (month) (day) (year)
(c) Cemetery or crematory
Location Philadelphia, Pa.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

(a) JAN 28 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-27 1947 at 12 Noon

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25 1947 to 1-27 1947. and that I last saw h[illegible] alive on 1-27 1947.

Immediate cause of death Coronary Cardiac Cessation

Due to Uremia and Kidney Shutdown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Workman, M. D.
Address Univ. Hosp. Date signed 1-27-47

VS 150

G47967

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 124 B

G47967 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2025 W Fayette
(c) Hospital or institution:
Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Ca a
(c) City or town Herald Harbor
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Gilbert Ahlgren

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Ora Eliza Ahlgren
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 27 - 1903

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 44 43 | | 1 | hr. min. |

9. Birthplace Illinois
(Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Ora Eliza Ahlgren
(b) Address Herald Harbor, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 30 47 (month) (day) (year)
(c) Cemetery or crematory
Location Annapolis Md

18 (a) Funeral director D L Hopkins & Son
(b) Address Annapolis Md

(a) Jan 28 1947 (b) William M. Barr
(Date filed by registrar) (Signature of registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1947, at 1 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 11 1947 to Jan 28 1947 and that I last saw h alive on Jan 28 1947.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Advanced Pulmonary Tuberculosis of both lungs | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William M. Barr M. D.
Address Bon Secours Hosp Date signed 1/30/47

X

G47968

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

107

G47968 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Road.
(c) Hospital or institution: Ashburton Nursing Home. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) ?
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5736 Ridgedale Road. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: BERTHA O. SUNDHEIMER.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Samuel Sundheimer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1862.

8. AGE: Years 84 | Months | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Abraham Oppenheimer,
13. Birthplace Germany.

MOTHER
14. Maiden Name Babette Einstein,
15. Birthplace Germany.

16 (a) Informant Mrs. Harry Goldsmith,
(b) Address 5736 Ridgedale Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1.28.47. (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom
Location Balto. Md.

18 (a) Funeral director Harris Sonneborn & Son
(b) Address 1002 Eutaw Place.

JAN 28 1947 (Date rec'd by registrar) (b) Thomas Hillegas, M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 26th. 1947, at P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14 1947 to Jan 26 1947 and that I last saw h[er] alive on Jan 26 1947.

Immediate cause of death: Bronchopneumonia — Duration 3 days
Due to: Senility
Due to: Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bernard J. Cohen, M. D.
Address Marlborough Apts. Date signed

X

G47969

507806

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1226

Registered No. G47969

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please leave write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) Lifetime
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Pikesville (If outside city or town limits, write RURAL and give town)
(d) Street No. Park Heights & Slade Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Elizabeth Heuman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Wm. Emanuel H.

6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) 2-27-10

8. AGE: Years 36 | Months 10/11 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Home wife.

11. Industry or business

FATHER — 12. Name Isaac Oppenheim

13. Birthplace Md.

MOTHER — 14. Maiden Name Florence Baumgarten

15. Birthplace Md

16 (a) Informant Record.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/47 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Balto. Hebrew

Location Baltimore, Md.

18 (a) Funeral director Claire Sonneborn & Son

(b) Address 1902 Eutaw Place

JAN 28 1947 (Date Rec'd by Registrar) Clayton Williamson Registrar

VS 150

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH Jan. 26, 1947, at 9:42 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1947 to Jan. 26 1947 and that I last saw her alive on Jan. 24 1947

| Immediate cause of death | Duration |
|---|---|
| Intestinal Obstruction | |
| Due to Scleroderma | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation 1/10/47

Major findings of operation Fecal Impaction - Colon

of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H S Turner

Address Johns Hopkins Hospital Date signed 1-28-47

X

G17970

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 108

G47970 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 1010 Linden Avenue
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 Linden ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Grace Hayes (STEWART)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | SEPERATED |

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 8-4-1906

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 40 | 5 | 21 | ____ hr. ____ min. |

9. Birthplace DANVILLE VA. (Town, county, and state)

10. Usual Occupation DOMESTIC

11. Industry or business

FATHER
12. Name WM HAYES.
13. Birthplace VA

MOTHER
14. Maiden Name MARY B WILLIAMS
15. Birthplace VA

16 (a) Informant MARY B HAYES.
(b) Address 1010 LINDEN AVE.

17 (a) Burial (b) Date thereof 1 29 47 (burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Milligan & Jackson
(b) Address 916 Pennsylvania ave

JAN 28 1947 Date rec'd by Local Registrar — Huntington Williams M.D. Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 1947, at 7 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Bilateral Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Nelsen M.D. (Medical Examiner.)
Date signed 1-25-47

X

G47971

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G47971

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2414 LAKEVIEW AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 62 YRS

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2414 LAKEVIEW AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** JACOB SIDLE

3 (b) If veteran, name war —
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | WHITE | MARRIED |

6 (b) Name of husband or wife SARAH
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | | | hr. min. |

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name ABRAHAM
13. Birthplace RUSSIA

MOTHER
14. Maiden Name ANNIE
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1-28-47 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location PHIL RD & HAMILTON AVE
18 (a) Funeral director VOLK LEWIS INC
(b) Address 1439 E. BALTO. ST

JAN 28 1947 (Date rec'd by registrar) (by) Washington Williamson, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-27 1947, at 6:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/27 1947 to 1/27 1947 and that I last saw alive on 1/27 1947

Immediate cause of death: Coronary Thrombosis — Duration 10 hours
Due to: Hemiat Arteriosclerosis Coronary Artery Disease — 4-6 Mos
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Theodore Cooper M.D.
Address 2201 Eutaw Place Date signed 1/27/47

VS 150

Theodore Cooper

G17972

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G17972

137a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address University Hosp
(c) Hospital or institution: Greene & Redwood Sts 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3640 Falls Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Harry Lemmert LEMMERT
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Caroline Brooks
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Sept. 1 - 1872
8. AGE: Years 74 | Months 4 | Days 26 | If less than one day: hr. min.
9. Birthplace: Balto Md (Town, county, and state)
10. Usual Occupation: Barber
11. Industry or business

FATHER
12. Name: John B. Lemmert
13. Birthplace: Germany

MOTHER
14. Maiden Name: Mary Dahlmeyer
15. Birthplace: Germany

16 (a) Informant: Mr. J. Vernon Lemmert
(b) Address: 211 Shady Nook Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29-47 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Balto Md

18 (a) Funeral director: Geo L Beyer Jr
(b) Address: 1512 Holland St

JAN 28 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1947, at 6.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 18 1947, to Jan. 27 1947, and that I last saw h. 1m alive on Jan 27 1947.

| Immediate cause of death | Duration |
|---|---|
| (a) Uremia | |
| Due to: Benign Prostatic Hypertrophy | |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: R E Bauer M. D.
Address: University Hosp Date signed: 27 Jan 47

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G47973

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G47973

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 202 S Fremont Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 202 S Fremont Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John A. Braun

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widower |

6 (b) Name of husband or wife Laura B. Braun
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15-1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 1 | 10 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER — 12. Name John A. Braun
13. Birthplace Balto Md

MOTHER — 14. Maiden Name Catherine Fahr
15. Birthplace Balto Md

16 (a) Informant Mr. John F. Braun
(b) Address 202 S Fremont Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/47 (month) (day) (year)
(c) Cemetery or crematory Western Cem
Location Balto Md

18 (a) Funeral director Geo L. Bayer Jr.
(b) Address 1512 Hollins St

JAN 28 1947 (Date rec'd by Registrar) (b) Hampton Williams M.D. (Registrar)

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** January 25, 1947, at M

**21.** I certify that death occurred on the date above stated; that I attended deceased from November 1945 to January 1947, and that I last saw him alive on January 20 1947

| Immediate cause of death | Duration |
|---|---|
| Recurrent congestive heart failure. | About 2 years. |
| Due to | |
| Hypertensive cardiovascular | |
| Due to disease and coronary sclerosis. | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo L. Bayer Jr. M. D.
Address 11 E. Chase St. Date signed 1.28.47

G47974 BCH G63000

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 182a

G47974 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5705 Swallow Lane Hospital, or Inst. No.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DEACEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5705 Swallow Lane (If rural give location)
(e) Citizen of foreign country? Holland (Yes or No)
If yes, name country

**3 (a) FULL NAME** Arthur Marine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/27/46

8. AGE: Years | Months 1 2 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore City, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Cleveland Marine

13. Birthplace S. C.

MOTHER 14. Maiden Name Rosa Mae Dunlap

15. Birthplace S. C.

16 (a) Informant Cleveland Marine

(b) Address 5705 S. Swallow Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-47 (month) (day) (year)

(c) Cemetery or crematory Ant. Auburn

Location Baltimore, Md.

18 (a) Funeral director Charles R. Lee

(b) Address 802 Madison Ave

19 JAN 28 1947 (b) Hampton Williams M.D. Registrar

VS 151

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** January 26, 1947 at 8:30 A.M.

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxia from suffocation.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/26/47 at ? 26/6 A.M.
(b) Where did injury occur? 5705 Swallow Lane Hospital
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? NO
(d) Means of injury Asphyxiation due to bed clothes

23. Signature George L. Merrill M.D. Medical Examiner.

Date signed 1/27/47

G47975 BC# G61533 BALTIMORE CITY HEALTH DEPARTMENT G47975
CERTIFICATE OF DEATH 186a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 402 asquith St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 402 asquith St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rodney Adams
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex m
5. Color or race c
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11 6 16
8. AGE: Years | Months 3 2 | Days 18 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Edward adams
13. Birthplace Baltimore md
MOTHER 14. Maiden Name Virginia Lansberg
15. Birthplace middletown ohio
16 (a) Informant Virginia adams
(b) Address 402 asquith St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 28 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn Md
18 (a) Funeral director Elroy O Wilson
(b) Address 516 orleans St
19 (a) JAN 28 1947 (Rec'd by registrar) Thomas Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH June 24 1947 at 1105 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull
Intracranial hemorrhage
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/23/47 at approx 1 2 P. M.
(b) Where did injury occur? 402 Asquith St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell from [illegible]

23. Signature George H. Merrill M.D. Medical Examiner.
Date signed 1/24/47

VS 151

G47976 B.C.H. 69343

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1/59

G47976
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 60 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 60 hrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 Greenwood Ave. #
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl (Cranblett) Cranblett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Newborn

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1947

8. AGE: Years | Months | Days: 2 | If less than one day: 60 hr. — min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Mr. [illegible] Cranblett
13. Birthplace [illegible]

MOTHER
14. Maiden Name Mary Clare Hobbes Booth
15. Birthplace England

16 (a) Informant Thomas Cranblett
(b) Address 6 Greenwood Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-28-47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Frank Crouch Son
(b) Address 900 N Arlington Ave

JAN 28 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 27 1947, at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1947 to Jan. 27 1947 and that I last saw h[illegible] alive on Jan. 27 1947.

Immediate cause of death: Cardio-Respiratory failure — Duration: Unknown

Due to: Prematurity — 60 hrs.

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. G. Ferrigni M. D.
Address Mercy Hospital Date signed Jan. 27/47

VS 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47977

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47977 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1309 Morling Ave.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 Morling Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Richard L. Lyons

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No. | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M. | W. | Widowed |

6 (b) Name of husband or wife Isabelle M (nee Cross)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1903

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 43 | 4 | 24 | hr. min. |

9. Birthplace Balto. Maryland
(Town, county, and state)
10. Usual Occupation Night Watchman
11. Industry or business Hdw. Furn. Store

FATHER
12. Name John L. Lyons
13. Birthplace England

MOTHER
14. Maiden Name Mary Whitman
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Mary Waltemyer
(b) Address 3719 Falls Rd Balto

17 (a) Burial (b) Date thereof 1 30 37
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Poplar Grove
Location Cockeysville, Md.

18 (a) Funeral director Sanders M. Brandt's
(b) Address Govans, Md.

19 (a) JAN 28 1937 (Date received by registrar) Wm. [illegible]

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 27 1937, at 8 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19

| Immediate cause of death | Duration |
|---|---|
| Myocardial failure | |
| Due to Myocarditis | |
| Due to Hypertension | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. P. Lyons M. D.
Address 1123 E Pleasant St Date signed 1-28-37

G47978

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G47978

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3112 Baker St.,
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3112 Baker St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** James Edwin Marlow

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Emma H. Marlow
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 24, 1864
8. AGE: Years 82 | Months 1 | Days 1 | If less than one day hr. min.
9. Birthplace Prince George Co., Md. (Town, county, and state)
10. Usual Occupation Retired--Mailing Dept.
11. Industry or business The Hubb Co.

FATHER
12. Name James H. Marlow
13. Birthplace Md.

MOTHER
14. Maiden Name Anna I. Rowe
15. Birthplace Md.

16 (a) Informant Mrs. Emma H. Marlow
(b) Address 3112 Baker St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 25, 1947, at 12.25 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7 1944 to 1/25/47 19, and that I last saw h[illegible] alive on 1/24/47 19.

| | Duration |
|---|---|
| Immediate cause of death: Acute dilitation of heart | about 2 days |
| Due to: Myocarditis about | 6 mo. |
| Due to: Advanced arterio-sclerosis | ? |
| Other Conditions: | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. E. White M. D.
Address 22 E. Saratoga St. Date signed 1-27-47

VS 150

G47979

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

Registered No. G47979

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital VT
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4526 Northwood Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William L. Stuckert

3 (b) If veteran, name war: 1st World War
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Anna
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Mar 1, 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 10 | 24 | hr. min. |

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Chief Probation Officer
11. Industry or business

FATHER
12. Name John. Stuckert
13. Birthplace Waynesboro Pa

MOTHER
14. Maiden Name Mary Wolf
15. Birthplace Lancaster

16 (a) Informant Mrs Anna Stuckert
(b) Address 4526 Northwood Dr

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/47 (month) (day) (year)
(c) Cemetery or crematory Immanuel
Location Lyndon Sta.

18 (a) Funeral director L. Heemann & Son
(b) Address 6067 Harford Rd.

19 (a) JAN 26 1947 (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/25 1947 at 10:27 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C-V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed 1/25/47

VS 151

G17980 4 pm dcd

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1826

G17980
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Turners Station
(If outside city or town limits, write RURAL and give town)
(d) Street No. 109 Chestnut St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Horace Gross

3 (b) If veteran, name war: Spanish War

3 (c) Social Security Account No. 265-07-7621

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Gross

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911 - Oct 11

8. AGE: Years: 35 | Months: 9 | Days: 15 | If less than one day: hr. min.

9. Birthplace: Ala
(Town, county, and state)

10. Usual Occupation: Miner

11. Industry or business

FATHER — 12. Name: Wesley Gross
13. Birthplace: Ala

MOTHER — 14. Maiden Name: Arittle Cox
15. Birthplace: Ala

16 (a) Informant: Mary Gross
(b) Address: 109 Chestnut St Turners Station

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 30 47 (month) (day) (year)
(c) Cemetery or crematory: Ala
Location

18 (a) Funeral director: Robert T. Williams
(b) Address: 1515 Pennsylvania Ave

19 (a) JAN 28 1947 (Date rec'd by registrar) Kenneth Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 1947 at 2:05 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Suffocation due to coal dust and small particles of coal in the upper respiratory tracks and lungs

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-26-47 at 4:30 A.M. 26/6
(b) Where did injury occur? 6400 St Helena Ave Children Points Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial plant While at work? yes
(d) Means of injury: Suffocated in coal dust

23. Signature: Howard J. Madeira M.D.
Medical Examiner.
Date signed 1-27-47

VS 151

G47981 7/7

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 33a

G47981
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the to the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 718 N. Caroline St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 718 N Caroline St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Isaac

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1890

8. AGE: Years 56 | Months 5 | Days | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name John Neal
13. Birthplace Balto Md

MOTHER 14. Maiden Name Addie ?
15. Birthplace Va

16 (a) Informant Isaac Young
(b) Address 718 N Caroline St

17 (a) Burial (b) Date thereof Jan 28 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cemetery
Location A. G. Conrad

18 (a) Funeral director Robert F. Williams
(b) Address 1515 McElderry St

19 (a) JAN 28 1947 (b) Washington Ave Md
(Date received by registrar) (Signature of registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1947, at 9:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1947 to Jan. 24 1947, and that I last saw R.Y. alive on Jan. 24 1947.

Immediate cause of death Bronchio-pneumonia — Duration 4 da.

Due to Grippe — 3 da.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert W. McDaniel M. D.
Address 807 N. Caroline St Date signed 1-27-47

X

G47382

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 74a

G47982 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4106 Groveland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 8/
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4106 Groveland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** EDWARD M. ALBAUGH

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Minnie L. Albaugh (nee Snyder) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 4 | 12 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER 12. Name Edward W. Albaugh
13. Birthplace Baltimore

MOTHER 14. Maiden Name Mary Mitchell
15. Birthplace Md.

16 (a) Informant Mrs. Howard H. Wright
(b) Address 3907 Forest Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JAN 28 1947 (Date received by Registrar) (b) [signature]

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 25, 1947 at 5:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 25 1937 to Jan 25 1947 and that I last saw h[e] alive on Jan 25 1947

Immediate cause of death: Acute infectio (Toxic) (-Uremia)
Due to Chronic Myocarditis (Myocardial failure)
Due to Chronic Emphatic Leukemia

| Duration |
|---|
| 1 week |
| 1 month |
| 1 yrs |

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 3403 Fairmount Blvd Date signed 1/27/47

X

G47983

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

G47983 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2611 Halcyon Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2611 Halcyon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ELLA CLARK WALSH

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | no |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widow |

6 (b) Name of husband or wife Charles E. Walsh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1863

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 3 | 24 | hr. min. |

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Clark
13. Birthplace Mass.

MOTHER
14. Maiden Name Elizabeth Knorr
15. Birthplace Md.

16 (a) Informant Mr. Emory Walsh
(b) Address 2611 Haldyon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JAN 28 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 27, 1947, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to Jan 27 1947 and that I last saw h[illegible] alive on Jan 26 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardio. Renal | 1 yr. |
| Due to Senil | |
| Due to | |
| Other Conditions Chr arthrit | 2 yr |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

28. Signature Fritz G Hinzen M. D.
Address 2700 Harford Road Date signed Jan 27 47

X JAN 27 1947

G47984

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 45F

G47984 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

GB

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital, Balto, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 69 days
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County A. A. Co.
(c) City or town Hanover (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 3A Hanover Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Smith, James Albert (James Albert Smith, Sr.)
3 (b) If veteran, name war SAW
3 (c) Social Security Account No. 214-18-9331

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Catharina F. Weber Smith
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) April 18, 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 9 | 9 | hr. min. |

9. Birthplace Prince George Co. Md. (Town, county, and state)
10. Usual Occupation None Laborer Foreman
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Robert Smith
13. Birthplace Prince George Co. Md.

MOTHER
14. Maiden Name Lorina Brooks
15. Birthplace Prince George Co. Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/30/47 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JAN 28 1947 (b) [illegible] Williams, M.D.
(Registered by Registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 27 1947, at 2:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29 1946, to Jan. 27 1947 and that I last saw him alive on Jan. 27 1947

Immediate cause of death: Carcinoma, squamous cell, right tonsil with extension to adjacent tissues — Duration UNKNOWN

Due to: (2) Pneumonia, lobular — UNKNOWN

Due to — UNKNOWN

Other Conditions: Edema of larynx severe and pulmonary emphysema (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

As above

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 1/27/47

X

G17985

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1/86a

G17985 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3029 Harlem Ave.
(c) Hospital or institution:

16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3029 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** SARAH ELLEN HARPER

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| female | white | widow |

6 (b) Name of husband or wife William W. Harper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 5 | 6 | hr. min. |

9. Birthplace Sumner, Missouri (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Elias B. Wantz
13. Birthplace Millers Station, Md.

MOTHER
14. Maiden Name Pauline Bricker
15. Birthplace Md.

16 (a) Informant Mrs. Grace H. Schaefer
(b) Address 3029 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/28/47 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cem.
Location Hampden, Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address 1947 Balto., Md.

19 JAN 28 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25, 1947 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/21 1941 to 1/25 1947 and that I last saw her alive on 1/25 1947.

| Immediate cause of death | Duration |
|---|---|
| Arteriosclerosis | ? |
| Due to Senility | ? |
| Due to Shock following fracture of left hip | 15 days |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 16/6
(a) Accident, suicide, or homicide Accident, contributory
(b) Date of occurrence 1/10/47 at nursing home
(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? None (Specify type of place) While at work? No
(e) Means of injury Fell + fractured left hip.
23. Signature Robert A. Reed M.D.
Address 3408 Windsor Ave Date signed 1/27/47

George E. Worrell MD

G47986

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G47986 Registered No. 107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2326 Barclay St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2326 Barclay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MAGDALENA ROCHE

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife William H. Roche
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 3 | 4 | hr. min. |

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Karl E. Weber
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Asel
15. Birthplace Germany

16 (a) Informant Mrs. Anna Rau
(b) Address 4300 Belview Ave.

17 (a) Burial (b) Date thereof 1/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

JAN 28 1947 [illegible] Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 25, 1947, at 4:00PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 1947 to Jan 25 1947 and that I last saw h. alive on Jan 25 1947.

| Immediate cause of death | Duration |
|---|---|
| Broncho-pneumonia | 3 days |
| Due to Bronchial asthma | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bernard Cohen M. D.
Address [illegible] Date signed 1-27-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47987 BC# G49724

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 108

Registered No. G47987

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland St Joseph's Hospt.
(b) Street address 1400 Caroline St.
(c) Hospital or institution Baltimore Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mos.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 N. Linwood Ave.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

**3 (a) FULL NAME** Carl Sears.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1946

8. AGE: Years | Months: 7 | Days: 9 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business Cant Ascertained

FATHER
12. Name Howard Robb
13. Birthplace Md

MOTHER
14. Maiden Name Norma Robb
15. Birthplace Md

16 (a) Informant Carl Sears
(b) Address 504 N Linwood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 28 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem Co
Location Catty

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2005 Arlington Av

19 (a) Jan 28 1947 (b) [illegible] Registrar
(Date received by registrar)

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Jan 25 1947, at 11.55 PM

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Jan 25 1947 and that I last saw alive on Jan 25 1947

Immediate cause of death
Cardio-Respiratory Failure
Due to Pneumonia
Lobar. Rt Lobe
Due to and Pleural effusion
left Side with Empyema
Other Conditions Cyst of left Kidney

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bilateral Empyema Chest

| Duration |
|---|
| |
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature Joseph M. Corder M. D.
Address St. Joseph's Hosp. Date signed 1/26/47

X

G47988

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46E

Registered No. G47988

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2725 Reggar ave (If not definite location)
(e) Citizen of foreign country? Risis (Yes or No)
If yes, name country

3 (a) FULL NAME Ruby Leslie

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| female | white | widowed |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 62 | 7 | 21 | hr. min. |

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name William Murray
13. Birthplace Maryland

MOTHER
14. Maiden Name Kentucky Wooden
15. Birthplace Maryland

16 (a) Informant Ernest Leslie
(b) Address 2725 Reggar ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29th (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address Reg & Alameda Pl. Williamsport, Md.

JAN 28 1947 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27 1947, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Jan 27 1947 and that I last saw deceased alive on Jan 26 1947

Immediate cause of death Carcinomatosis

Due to primary Carcinoma of Ovary

Due to

Other Conditions Hypostatic pneumonia, chronic cholecystitis
(Include pregnancy within 3 months of death)

Date of operation 12-21-46

Major findings of operation: Cholecystitis & Stomach, Resection of stomach & jejunum with Gastro Jejunal Anastomosis

of autopsy:

| Duration |
|---|
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard E. Martin
Address Maryland Gen. Hosp. Date signed 1-27-47 M. D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C17989 CWK-48365

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 186a

C17989

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
7-4-6-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) ?

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 Edmondson Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Adelaide Dennis

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | Widowed |

6 (b) Name of husband or wife Francis (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28-1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 3 | 23 | hr. min. |

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name John C. Barney
13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Sarah
15. Birthplace Pennsylvania

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof Jan 28 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Etherial Mem.
Location

18 (a) Funeral director Mrs. Katie P. Hilliges
(b) Address 822 W. Lehmans Ln.

JAN 28 1947 (Date rec'd by registrar) (b) Clayton Williams, M.D.

V S 150

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH January 21 1947, at 7:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1939 to Jan. 21 1947 and that I last saw h... alive on Jan. 21 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral hemorrhage | 5 hrs |
| accident | |
| Due to Fractured skull | 4 hrs |
| Due to | |
| Other Conditions Fracture of Rt femur | 1 mo |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 24/2
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 12-31-46 ? M
(c) Where did injury occur? Balto. City Hospitals Baltimore Maryland
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Balto. City Hosp. Entrance While at work? No
(Specify type of place)
(e) Means of injury Slipped and fell to floor

23. Signature Howard J. Orrell M.D.
Address Balto. City Hosp. Date signed 1-28-47

Howard J. Mercier, M.D. +

G47990

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 H

Registered No. G47990

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 707 N. Streeper Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 707 N. Streep er Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3. (a) FULL NAME** ANGELLO PASSARELLA

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Libare Passarella
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 2, 1892.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 | 5 | 23 | hr. min. |

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Baltimore Transit Company
11. Industry or business

FATHER
12. Name Nicholas Passarella
13. Birthplace Italy

MOTHER
14. Maiden Name Carmilla Mantigna
15. Birthplace Italy

16 (a) Informant Libare Passarella(wife)
(b) Address 707 N. Streeper Street#5

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

JAN 28 1941 (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 25 1947, at 9:15 P. M.
21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 1946, to Jan. 25 1947, and that I last saw him alive on Jan. 25 1947.

| | Duration |
|---|---|
| Immediate cause of death: Gastric hemorrhage | 5 days |
| Due to: Retro-peritoneal lymphosarcoma | unknown |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)
Date of operation Dec. 1946
Major findings of operation: Retro-peritoneal lymphosarcoma with metastases
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Adam Schwiss M. D.
Address 6232 Belair Road Date signed Jan. 27 1947

VS 150

G47991

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

G47991 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1107 Sharp St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 Sharp St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Nancy Hammock

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | M |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1905

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 41 | 10 | 21 | hr. min. |

9. Birthplace Georgia (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Jim Hill
13. Birthplace Georgia

MOTHER
14. Maiden Name Mary Coleman
15. Birthplace Ga

16 (a) Informant Cora Lewis (D)
(b) Address 1107 Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-28-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Md

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Monument St

19 JAN 28 1947 (Date received by registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 26 1947, at 9:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1946 to Jan 26 1947, and that I last saw her alive on Jan 26 1947.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma Rt Breast | 3 yrs |
| Due to with generalized Metastases | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation Feby 1939
Major findings of operation: Carcinoma left breast
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Karl Pass M.D.
Address 1001 Wilkens Ave Date signed 1-26-47

G47992

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. G47992

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 808 Tyson St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto. City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 808 Tyson St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Alexander Chase

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 57 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name Henry Chase
13. Birthplace Cambridge Md

MOTHER
14. Maiden Name Katie Dampson
15. Birthplace Cambridge Md

16 (a) Informant Minnie Chase
(b) Address 808 Tyson St

17 (a) ... (Burial, cremation, or removal) (b) Date thereof 1 28 47 (month) (day) (year)

(c) Cemetary or crematory Mt. Zion
Location Baltimore Md

18 (a) Funeral director Archibald H. Taddie
(b) Address 2101 McCulloh St

19 JAN 28 1947 Huntingtor Williams, M.D.

VS 180

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jany 26 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jany 14 1947, to Jany 26 1947, and that I last saw him alive on Jany 25 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 12 Days |
| Due to | |
| Due to | |
| Other Conditions None | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. K. Peltekian M. D.
Address 817 Hamilton Ave Date signed Jan 27/47

PELTEKIAN X

G47993

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH / 61

G47993 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St.
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 4115 E. Lombard St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs. Ella Nichols Nicoletti

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F. | W | Married |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 8 | 13 | hr. min. |

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business home

FATHER
12. Name Michele Bocchino
13. Birthplace Italy

MOTHER
14. Maiden Name Teresa Biancanello
15. Birthplace Italy

16 (a) Informant Joseph Nichols (Husband)
(b) Address 4115 E. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 30/47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Rd. Baltimore Md.

18 (a) Funeral director Frank Della Vael
(b) Address 52 N. Morley St.

19 (c) JAN 28 1947 (Date received by Registrar) [illegible] for Williams M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26th 1947, at 4:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1946 to Jan 26 1946 and that I last saw h[illegible] alive on Jan 26 1946.

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | |
| and | |
| Due to Anemia due to | |
| Diabetes. | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry T. Wilson Jr. M. D.

Address St. Joseph's Hosp Date signed 1/26/47

Henry T. Wilson, Jr. Howard D. Thomas, M.D. X

G47994

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

186a

G47994 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: West Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town 3727 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3727 W Garrison Avenue (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Henry O. Carlisle Henry O. Carlile (E.P)

3 (b) If veteran, name war

(c) Social Security Account No. 214-01-979

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife Mary A. Carlile

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Jan 27 - 1889

8. AGE: Years 57 | Months 11 | Days 30 | If less than one day ..... hr. ..... min.

9. Birthplace Harford Co. Md (Town, county, and state)

10. Usual Occupation Coffee Roaster

11. Industry or business

FATHER
12. Name Thomas W. Carlile
13. Birthplace Delaware

MOTHER
14. Maiden Name Julia A. Hoffa
15. Birthplace Balto. Md.

16 (a) Informant Mary A. Carlile
(b) Address 3727 W Garrison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 29 1947 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore, Md.

18 (a) Funeral director Ellis J. White
(b) Address 2240 Old Spring Lane

19 (a) JAN 28 1947 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 26, 1947, at 7.30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull.
Intracranial hemorrhage
Due to Fractured ribs

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 27/18
(a) Date of injury 1-25-47 at about 4. p. M.
(b) Where did injury occur? Yard-3727 W. Garrison Ave
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Fell while pruning -to ground

23. Signature George L. Mattill M.D.
Medical Examiner.
Date signed 1/27/47

G47995

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1813

G47995

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or other institution (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 934 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

**3 (a) FULL NAME** Walter Burns Jr.
3 (b) If veteran, name war
3 (c) Social Security Account

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced (write) Single
6 (b) Name of husband or wife
6 (c) If living, give age
7. Birth date of deceased (mo., day, yr.) Nov. 15, 1936
8. AGE: Years 10 | Months 2 | Days 10 | If less than one day hrs. min.
9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Walter Burns Sr.
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Pauline Turner
15. Birthplace Maryland

16 (a) Informant Walter Burns Sr.
(b) Address 934 Madison Ave.

17 (a) Burial (b) Date thereof 1-30-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Elday Hill Md.

18 (a) Funeral director Charles R. Law
(b) Address 102 Madison Ave.
(c) Washington Hollins Md.
(Signature of person acting for funeral director)

JAN 28 1947
(Date received by registrar)

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 1/25 1947 at 3:25 P.M.

**21.** I certify that death occurred on the date above stated, that I attended deceased from 1/25 1947 to 1/25 1947, and that I last saw h[illegible] alive on 1/25 1947

The disease causing death was first manifested on (date) 1/25 1947
Contributory (secondary) causes
Duration

Due to Chronic Rheumatic Endocarditis
Due to Congestive Heart Failure
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation

PHYSICIAN
Underline the cause to which death should be charged statistically.

**22. If death was due to external causes, fill in the following:**
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23. Signature** Robert L. Forrenberg M.D.
Address University Hosp. Date signed 1/26

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47996

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G47996 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2613 E. Preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2613 E. Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Carmela Pasquale

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Libero Pasquale

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) March 30 1877

8. AGE: Years 69 | Months 9 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Dominic Mastergeard
13. Birthplace Italy

MOTHER 14. Maiden Name Teresa Libertoge
15. Birthplace Italy

16 (a) Informant Libero Pasquale
(b) Address 2613 E Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road & Moravia

18 (a) Funeral director Geo. E. Miller Jr.
(b) Address 2437 E Oliver St

19 (a) (b) Washington Williams, Md.

JAN 28 1947

V S 130

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 27 1947, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/12 1936 to 1/27/47 1947, and that I last saw h[illegible] alive on 1/26 1947

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | 12-24-46 |
| Due to Hypertension C.V.D | 9 yrs. |
| Due to | |
| Other Conditions Auricular Fibrillation | 2 yrs. |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Karl Hamman M. D.
Address 212 N Patterson Date signed 1/27/47

Phone X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47997 — BALTIMORE CITY HEALTH DEPARTMENT — G47997

# CERTIFICATE OF DEATH

94a

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 423 N Patterson Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL, and give town)
(d) Street No. 423 N Patterson Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Alexander Woron

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-07-03

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Fannie Woron

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not know

8. AGE: Years About 58 | Months | Days | If less than one day hr. min.

9. Birthplace Russian (Town, county, and state)

10. Usual Occupation Oilman

11. Industry or business

FATHER
12. Name William Woron
13. Birthplace Russian

MOTHER
14. Maiden Name not known
15. Birthplace Russian

16 (a) Informant Mrs. Fannie Woron
(b) Address 425 N. Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-47 (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russian
Location Stoney Run, Balto. Md.

18 (a) Funeral director John A. Grebliunas
(b) Address 423 S. Paca St

JAN 28 1947 (Date rec'd by registrar) (b) Hamilton Williams M.D. Registrar

VS 181

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 24 1947, at 7:05 P.M.

21. I certify that I took charge of the remains described above and held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Helbrecht M.D. Medical Examiner.
Date signed 25 Jan 47

G47998 BALTIMORE CITY HEALTH DEPARTMENT G47998
Registered No.

# CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave.
(c) Hospital or Institution Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 13 Linden Terrace
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Mabel Harward

3 (b) If veteran, name war: no
3 (c) Social Security Account No. no

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Edwin W. Harward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 12, 1878

8. AGE: Years 68 | Months 6 | Days 15 | If less than one day: hr. min.

9. Birthplace: Harford Co. Maryland
(Town, county and state)

10. Usual Occupation: House Wife
11. Industry or business

FATHER
12. Name: Dr Charles Streett
13. Birthplace: Jarrettsville Harford Co.

MOTHER
14. Maiden Name: Lavinia Streett
15. Birthplace: Rocks, Md.

16 (a) Informant: Mr. Charles E. Harward
(b) Address: 1653 Normal Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/47 (month) (day) (year)
(c) Cemetery or crematory: Moreland Mem. Pk.
Location: Balto. Co., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Signature of registrar) (b) Date received: JAN 28 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1947, at 3.05 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 1/20 1947 to 1/27 1947, and that I last saw h. alive on 1/27 1947.

Immediate cause of death: Heart failure — Duration
Due to: Hypertensive Heart and vascular disease
Due to:
Other Conditions: Sarcoma of uterus
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: W. W. Krepp M. D.
Address: Md. Gen. Hosp. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G47999 G13999 BCH BALTIMORE CITY HEALTH DEPARTMENT G61129 CERTIFICATE OF DEATH 1042 Registered No. G13999

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 Quantrill Way (If rural give location)
(e) Citizen of foreign country? Armistead Parker (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ella E. Morehead

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Infant |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6. 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 2½ | 20 | hr. min. |

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

| | |
|---|---|
| FATHER 12. Name | Robert. Morehead |
| FATHER 13. Birthplace | Baltimore Md. |
| MOTHER 14. Maiden Name | Ellen Tait |
| MOTHER 15. Birthplace | Baltimore Md. |
| 16 (a) Informant | Robert Morehead |
| (b) Address | 105 Quantrill Way |
| 17 (a) Burial (Burial, cremation, or removal) | (b) Date thereof Jan 27 1947 (month) (day) (year) |
| (c) Cemetery or crematory | Mount Carmel |
| Location | Edmondson Ave |
| 18 (a) Funeral director | Rendell & Keppel |
| (b) Address | 615 S Hwy Baltimore |
| 19 (a) Date received | (b) Registrar |

JAN 28 1947 Huntington Williams, M.D.

VS 151

**MEDICAL CERTIFICATION** 25

**20. DATE OF DEATH** January 26 1947 at 11 A. M

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

**IMMEDIATE CAUSE OF DEATH** Upper respiratory infection with inanition.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 1/27/47

Cert Certificate
G48000
G-69206

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH V 159

G48000 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wilkens + Caton Aves
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Lansdowne (If outside city or town limits, write RURAL and give town)
(d) Street No. 205 First Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hahn
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1/27/47
8. AGE: Years Months Days If less than one day 7½ hr. min.
9. Birthplace Baltimore, Md. (town, county, and state)
10. Usual Occupation Infant
11. Industry or business
FATHER 12. Name Charles
13. Birthplace
MOTHER 14. Maiden Name Mgt Southerington
15. Birthplace Ohio
16 (a) Informant Hosp Rec.
(b) Address
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 28 47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd
18 (a) Funeral director Monroe Chapel
(b) Address 572 S Caton Ave
19 (a) Filed by registrar 1-28-1947 (b) Signature Walter Williams Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-28 1947, at 2:05 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 1-27 1947 to 1-28 1947.
and that I last saw alive on 1-28 1947.

Immediate cause of death Prematurity - 7 months — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Robert J. Lericka
Address St Agnes Hosp. Date signed 1/28/47

VS 150

G18001 ✓ G18001

G18001

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

116

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: Dukeland + Raynor Ave
(c) Hospital or institution: West Balto Genl Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5310 Cordelia Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harvey Stottelmeyer
3 (b) If veteran, name war
3 (c) Social Security Account No. 212-05-7428

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | married |

6 (b) Name of husband or wife Rhoda R.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) August 22 1881

| 8. AGE Years | Months | Days | If less than one day hr. | min. |
|---|---|---|---|---|
| 65 | 5 | 5 | | |

9. Birthplace Boyds Mont Co. Md (Town, county, and state)
10. Usual Occupation Retired Electrical Dispatcher
11. Industry or business East Electric Co.

FATHER
12. Name Hiram Stottelmeyer
13. Birthplace Frederick Co. Md

MOTHER
14. Maiden Name Mahala Schaeffer
15. Birthplace Frederick Co. Md.

16 (a) Informant Wife Last Hosp. Records.
(b) Address Dukeland & Raynor Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-29-47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn Md

18 (a) Funeral director Layne Byers
(b) Address 5025 Pk Heights Ave

DAN 28 1947 (Date received by registrar) Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/27 1947 10 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/26 1947 to 1/27 1947.
and that I last saw him alive on 1/27 1947.

| Immediate cause of death | Duration |
|---|---|
| Shock | |
| Due to Pneumo-Hydro Thorax | |
| Due to Ruptured Esophagus | |
| Other Conditions Uremia | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Bachrach M. D.
Address W S & H Date signed 1-27-47

COPIES: Use typewriter or ink. Write plainly and legibly. Fill in all items. Use black ink or indelible pencil. Write the ordinary signature of the physician. Write the cause of death clearly and legibly.

VS 150

G18002

508517.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1248

G18003

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2309 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Patrick Raughbridge

3 (b) If veteran, name war

3 (c) Social Security Account No. 239-09-6405

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Divorced |

6 (b) Name of husband or wife Fannie L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-10-00

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | 4 | 16 | hr. min. |

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Taxi Dispatcher.
11. Industry or business Sun Cab Co.

FATHER
12. Name James Raughbridge
13. Birthplace N.C.

MOTHER
14. Maiden Name Hettie Fisher
15. Birthplace N.C.

16 (a) Informant Records
(b) Address

17 (a) Burial (b) Date thereof 1/29/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location A. A. Co. Md.

18 (a) Funeral director Wm. Liam Cook Inc.
(b) Address 1217 St. Paul St

19 (a) Filed JAN 29 1947 (b) Registrar Hampton Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 26 1947, at 1025 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 21 1947 to Jan. 26 1947 and that I last saw him alive on Jan. 27 1947.

| Immediate cause of death | Duration |
|---|---|
| CIRRHOSIS OF LIVER | |
| Due to | over |
| Due to | |
| Other Conditions BERI BERI HEART DIS. ABSCESS LEFT KIDNEY | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy: ABOVE

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas S. Stephens M. D.
Address Johns Hopkins Hospital Date signed 1-27-47

X

G48003 Cross 25th St. VN. 0619

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

131a

Registered No. G48003

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 219 E. 25th. St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 219 E. 25th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Fannie A. Dames

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1869

8. AGE: Years 77 | Months 4 | Days 24 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Augustus F. Dames
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Posliff
15. Birthplace England

16 (a) Informant Bessie Thompson
(b) Address 219 E. 25th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/30/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Md.

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) Received by (b) Registrar
JAN 29 1947

VS 155

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 8th 1947, to Jan. 28th 1947, and that I last saw h[illegible] alive on Jan. 28th 1947.

| Immediate cause of death | Duration |
|---|---|
| Uraemia | 2 days |
| Due to Hypertensive Cardio-Vascular, renal disease | 10 yr. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George E. Cross, M. D.
Address 28 W 25th St Date signed 1-28-47

X

G18004

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 122B

Registered No. G18004

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2328 Annapolis Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mr Joseph W. Kyler, Jr.

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | C | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 27-1902

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 44 | 5 | — | hr. min. |

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Tavern Prop.
11. Industry or business

FATHER
12. Name Joseph Kyler Sr.
13. Birthplace Md.

MOTHER
14. Maiden Name Bertrade Isaacs
15. Birthplace Md.

16 (a) Informant Grace L. Martin
(b) Address 2414 Puget

17 (a) Burial (b) Date thereof 1-30-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. City
18 (a) Funeral director Samuel W. Sullivan Jr.
(b) Address

19 (c) JAN 29 1947 Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 27 1947 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1947 to Jan 27 1947 and that I last saw h[illegible] alive on Jan 27 1947

Immediate cause of death

| | Duration |
|---|---|
| Gangrene of bowel (Small) | |
| Due to Intestinal obstruction | |
| Due to Cause unknown | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation Jan 27, 1947
Major findings of operation: Intestinal obstruction
of autopsy: Gangrene of bowel

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address St Jos. Hospt. Date signed 1/30/47

RAKOS

G18005

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 75B

Registered No. G18005

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 902 Argyle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Rakos

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| FR | Negro | Widowed |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1902

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 45 | | | hr. min. |

9. Birthplace Eastern, MD.
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name HAYMON
13. Birthplace Md.

MOTHER
14. Maiden Name MARY ?
15. Birthplace Md.

16 (a) Informant MRS MARY Widgeon
(b) Address 906 Shields Place

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1-29-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location H.H. Co. Md.

18 (a) Funeral director MRS FRANCIS A. HENSLEY
(b) Address 514 W. Biddle St.

JAN 29 1947
(Date rec'd by registrar)

(b) Huntington Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/26/47 19 , at 6⁰⁰ PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/23 1947 to 1/26 1947 and that I last saw h.[illegible] alive on 1/26 1947

Immediate cause of death — Duration

Acute yellow Jaundice

Due to

Due to

Other Conditions Splenomegaly. CPC of Liver & Lungs. Dehydration
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Raymond Hay M.D.
Address Provident Hosp Date signed 1/28/47

VS 150

G48006

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

121B

Registered No. G18006

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 619 N. Payson St.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1920 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** JOHN B. CANNON.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Divorced |

6 (b) Name of husband or wife May Cannon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | 10 | 025 | hr. min. |

9. Birthplace Queen Anns Co., Md.
(Town, county, and state)
10. Usual Occupation Ice Business
11. Industry or business

FATHER
12. Name Walter Cannon
13. Birthplace Queen Anns Co., Md.

MOTHER
14. Maiden Name Emma Lane
15. Birthplace Queen Anns Co., Md.

16 (a) Informant Mrs. Esther Downey
(b) Address 1920 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 29 1947 Hamilton Williams M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 26, 1947, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 1946 to Jan 26 1947 and that I last saw h[illegible] alive on Jan 24 1947.

| Immediate cause of death | Duration |
|---|---|
| Hypertensive Cardio-Vascular Disease | 3 years |
| Due to | |
| Due to | |
| Other Conditions Chronic Nephritis | 2 months |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert H. Katz M.D.
Address 2038 Wilkens Ave Date signed Jan 27 '47

935

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48007

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G48007

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4303 Hampnett Ave.
(c) Hospital or institution: Pine Ridge Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 McKean Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** EMMA M. SCHMITZ

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | no |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife. Charles H. Schmitz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 8 | 16 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Louis Snyder
13. Birthplace Unknown

MOTHER
14. Maiden Name Augusta Treff
15. Birthplace Unknown

16 (a) Informant Mr. John C. Snyder
(b) Address 3707 Farndale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/30/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JAN 29 1947 (Date received by Registrar) (Signature of Registrar) Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 27, 1947, at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 23 1947 to Jan. 27 1947, and that I last saw her alive on Jan. 26 19 47.

| | Duration |
|---|---|
| Immediate cause of death: Cerebral hemorrhage | 3 Days |
| Due to: Arteriosclerosis Hypertensive heart disease | |
| Due to: | |
| Other Conditions: Uremia | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. V. Harlold M. D.
Address 4706 Harford Road Date signed 1/28/47

VS 150

G18008

508 432

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

159

Reg. No. G15903

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2687 Eagle St. Eagle (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Baby Girl Penrance.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-26-47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 1 | hr. min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William H. Penrance
13. Birthplace Penn.

MOTHER
14. Maiden Name Elsie Mae Carpenter
15. Birthplace Penn

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 28 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 29 1947 (Date rec'd by registrar) H. Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan - 21 1947, at 9.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan - 20 1947, to Jan - 21 1947 and that I last saw H alive on Jan - 21 1947.

| Immediate cause of death | Duration |
|---|---|
| Resp. Failure | |
| Due to Prematurity + Atelectasis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Barton Childs M. D.
Address Johns Hopkins Hosp. Date signed

VS 190

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18009

CMK-89568

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

131a

Registered No. G18009

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 4- 21-
(e) Length of stay in Baltimore (yrs., mos., or days) 83-10-2-

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 501 S. Bethel Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Samuel Hillgardner

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18-1863

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 10 | 2 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Hillgardner
13. Birthplace Germany

MOTHER
14. Maiden Name Helen Apple
15. Birthplace Germany

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 28 1947 Commissioner of Health

18 (a) Funeral director
(b) Address

JAN 29 1947 (Date rec'd by Registrar) Huntington Williams M.D. (Signature of Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 20- 1947, at 8:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 29 1944 to Jan. 20 1947 and that I last saw him alive on Jan. 20 1947

Immediate cause of death Uremia — Duration 1 wk.

Due to Arteriolonephrosclerosis — yrs

Due to Benign hyperten Arteriosclerosis — yrs

Other Conditions Pernicious anemia — yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. E. Robinson Jr M. D.
Address Balto. City Hosp. Date signed 1/29/47

V S 150

G48010 BC# D 68990

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

159

G48010 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: DuKaland & Ragner
(c) Hospital or institution: W. Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 1 day
(e) Length of stay in Baltimore (yrs., mos., or days): 1 day

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: Md. (b) County: Baltimore
(c) City or town: Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 525 Carrollton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME:** Robert Johnston Plum
3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | W | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 21, 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 1 | hr. min. |

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name: George Plum
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Ethel Johnston
15. Birthplace: Balto. Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Local Johns Hopkins Medical School JAN 28 1947

18 (a) Funeral director: Commissioner of Health
(b) Address

19 JAN 29 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-22 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-21 1947, to 1-22 1947, and that I last saw h[illegible] alive on 1-22 1947.

| Immediate cause of death | Duration |
|---|---|
| Atelectasis | |
| Due to | |
| Due to | |
| Other Conditions Pneumonia, lobar | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Not done

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: E. A. Triplett M. D.
Address: W. Balto Gen. Hosp. Date signed: 1-24

VS 150

G18011 BC# D 68989

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

Registered No. G18011

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Dukeland & Reynes
(c) Hospital or institution: W. Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7days
(e) Length of stay in Baltimore (yrs., mos., or days) 7days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5215 Dartmouth Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

**3 (a) FULL NAME** Carol Ann Plum

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22, 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 7 6 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George Plum
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Ethel Johnston
15. Birthplace Baltimore, Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 28 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 29 1947 (Date filed by Registrar) Washington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-27 1947, at 4:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-21 1947 to 1-27 1947 and that I last saw her alive on 1-27 1947.

| Immediate cause of death | Duration |
|---|---|
| (a) Aspiration pneumonia | |
| Due to | |
| Due to | |
| Other Conditions (1) Infected Hydrocele (2) Prematurity | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: Not obtained

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. S. Thrasher M. D.
Address W. Balto Gen. Hosp. Date signed 1-27-47

VS 150

Birth Certificate

G48012

Y-69047

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 157a

Registered No. G48012

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution:
Church Home & Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr 8 min
(e) Length of stay in Baltimore (yrs., mos., or days) 1 hr 8 min

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 303 E St Spanows Pt. 19
(If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Baby Girl Fuleher
3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex female
5. Color or race white
6 (a) Single, married, widowed, or divorced single
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1-26-47
8. AGE: Years — Months — Days — If less than one day 1 hr. 8 min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation infant
11. Industry or business

FATHER
12. Name Leslie Fuleher
13. Birthplace Virginia

MOTHER
14. Maiden Name Clentia Vale Pond
15. Birthplace Maryland

16 (a) Informant Leslie Fuleher
(b) Address 303-E Street Sparrows Pt.

17 (a) Burial, cremation or removal (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location Johns Hopkins Medical School JAN 28 1947
18 (a) Funeral director Commissioner of Health
(b) Address Huntington Williams, MD
JAN 29 1947 (Date rec'd by registrar) (S) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-26 1947 at 10:20 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 1-26 1947 to 1-26 1947 and that I last saw her alive on 1-26 1947.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | Terminal |
| Due to Congenital anomalies | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Hydrocephalus X
of autopsy Congen. absence of left diaphragm

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John A Rosin M.D.
Address Church Home & Hospital Date signed Jan 27 47

X

VS 150

G48013 BCH G66252 ✓ G48013

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 27

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1419 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby g Beatrice Knight

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Negro | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 25 46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 9 d | hr. min. |

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Clarence Foulkes
13. Birthplace Balto. Md

MOTHER 14. Maiden Name Beatrice Knight
15. Birthplace Balto. Md

16 (a) Informant Beatrice Knight
(b) Address 1419 W. Mulberry St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JAN 27 1947

18 (a) Funeral director Commissioner of Health
(b) Address

JAN 29 1947 (Date rec'd by registrar) Huntington Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29, 1946, at 9 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21, 1946, to Dec 29, 1946, and that I last saw him alive on Dec 29, 1946

| Immediate cause of death | Duration |
|---|---|
| Prematurity | 6 hrs. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Louis Jones M. D.
Address 1100 Division St Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48014

BALTIMORE CITY HEALTH DEPARTMENT

ZACKEARY CERTIFICATE OF DEATH 108

Register No. G48014

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1234 Sharp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs.) mos., or days) (18)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1234 Sharp St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ben Zackeary

3 (b) If veteran, name war —

3 (c) Social Security Account No. 721-09-9586

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| m | c | — |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/11/1906

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 40 | 10 | 15 | hr. min. |

9. Birthplace Georgia (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name John Zackeary
13. Birthplace Ga.

MOTHER 14. Maiden Name Mary Harris
15. Birthplace Ga

16 (a) Informant Lucy Zackeary
(b) Address 1234 Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A. A. Co., Md

18 (a) Funeral director Isaiah L Brown & Son
(b) Address 106 N Montgomery St

19 JAN 29 1947 [illegible] for Williamson, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 26 1947 at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10-1947 to 1-26-1947 and that I last saw alive on 1-20-1947

| Immediate cause of death | Duration |
|---|---|
| Pneumonia | |
| Due to — | |
| Due to V | yrs. |
| Other Conditions V | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas C Carter M. D.
Address 1016 N. Sharp St Date signed 1-30-47

VS 190

G48015

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 121

Registered No. G48015

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1215 Light St
(c) Hospital or institution: So. Balto. Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1737 S. Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anna Hoffman

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W. | W. |

6 (b) Name of husband or wife Freeman C. Hoffman 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64. | 5 | 20. | hr. min. |

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Tom Steinbeck

13. Birthplace Balto Md

MOTHER 14. Maiden Name Magdalene Stuth

15. Birthplace Baltimore.

16 (a) Informant

(b) Address

17 (a) Interment (b) Date thereof 1/31/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location Reese Highway

18 (a) Funeral director J. Fabian Leahy

(b) Address 3 E. Lafayette St

1-29-1947 (Date received) Hunter Funeral Home, Williams, Md. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-28 1947, at 3 21 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25 1947, to 1-28 1947, and that I last saw her alive on 1-28 1947.

| Immediate cause of death | Duration |
|---|---|
| Septicemia | |
| Due to Appendicial abscess. | |
| Due to Gangrenous appendix | |
| Other Conditions Hypertension Cardio-vascular disease | |

(Include pregnancy within 3 months of death)

Date of operation 1-25-47.

Major findings of operation Gangrenous appendix

Autopsy Appendectomy.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no)
(e) Means of injury

23. Signature [illegible] M.D.

Address 1213 Light St Date signed 1-29-47

VS 150

G48016

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G48016

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd St + Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 da
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 513 Normandy
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Edith M. Slinkman

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | Wh | Single |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 5, 1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | 2 | 23 | hr. min. |

9. Birthplace Balto, Md (Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business Hats

FATHER
12. Name William E. Slinkman
13. Birthplace Md

MOTHER
14. Maiden Name Mary Moore
15. Birthplace Md

16 (a) Informant Mrs C. J. Kammer
(b) Address 513 Normandy Ave. Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 31 '47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave
18 (a) Funeral director Harry H Wetzel
(b) Address 4101 Edmondson Ave

19 JAN 29 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-28-47 19 at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-8 1947 to 1-28 1947 and that I last saw her alive on 1-28 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral embolism | 21 da |
| Due to Myocardial failure & mural thrombi formation | 2+ yrs |
| Due to H.C.V.D. | |
| Other Conditions Embolus to left brachial artery & beginning Gangrene. (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward L. Jones Jr. M. D.
Address Union Mem. Hosp. Date signed 1-25-47

VS 150

G48017
507700

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 50

Registered No. G48017

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 21 N. Spring St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Sarah Watson Davis

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Black | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-30-86

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 11 | 28 | hr. min. |

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Isaac Westcott
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Graham
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Eltonhead
18 (a) Funeral director Eltonhead
(b) Address 1000 Bradford Ave
19 (a) JAN 29 1947 (b) Signature by Hunter Williams

VS 150

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH Jan-27 1947, at 10.20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-8 1947 to Jan-27 1947, and that I last saw her alive on Jan-27 1947.

| | Duration |
|---|---|
| Immediate cause of death: Bronchopneumonia | 1 wk |
| Due to: Carcinoma of breast | 3 yrs |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Mason M.D.
Address Johns Hopkins Hosp Date signed 29 Jan 47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48018

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. G48018

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 411 N.Castle St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 411 N.Castle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Theresa Koehler

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| -- | -- |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife John Koehler Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22,1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 6 | 4 | hr. min. |

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name -- Wollschlager
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant John Koehler Jr.
(b) Address 411 N.Castle St.

17 (a) Burial (b) Date thereof Jan.30,1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Balto, Md.

18 (a) Funeral director Philip Newburg Sons
(b) Address 2024 Orleans St.

JAN 29 1947 (b) [illegible]
(Date received by registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 26/47 19.., at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5, 1938 to Jan. 26 1947 and that I last saw her alive on Jan. 25, 1947

| Immediate cause of death | Duration |
|---|---|
| Chronic bronchitis | 2 yrs |
| Paraplegia, left, after cerebral hemorrhage | 2½ yrs |
| Due to Myocardial insufficiency | 9 days |
| Due to Pulmonary edema | 1 day |
| Other Conditions Essential arteriosclerosis 9 yr | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Benedict Bronnenkant, M. D.
M. D.
Address 3037 O'Donnell St Date signed

JAN 28 1947

G48019

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

92E

G48019 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1011 N. Carolina
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 N. Carolina St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

**3 (a) FULL NAME** Blanche L. Smith

3 (b) If veteran, name war: No

3 (c) Social Security Account No.:

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-5-1899

8. AGE: Years 47 | Months 9 | Days 20 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Sullivan Wright
13. Birthplace Balto Md

MOTHER
14. Maiden Name Martha King
15. Birthplace Balto Md

16 (a) Informant Mary Watson (Sister)
(b) Address 1011 N. Carolina St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A. County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (Signature and title) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 25 1947, at 12:12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1947, to Jan 24 1947, and that I last saw h[illegible] alive on Jan 23 1947

| Immediate cause of death | Duration |
|---|---|
| Cardiac decompensation | 8 Days |
| Due to Pneumonia | 8 Days |
| Due to Endocarditis | yrs |
| Other Conditions Staphylococcus | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. D. Phelps M. D.
Address 1422 E. Preston Date signed 1/24/47

VS 150

G48020 TIBBS

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93a

G48020 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 449 Walton Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 800 Lexington St. Apt. 2 (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche Tibbs

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23-1895

8. AGE: Years 51 | Months 11 | Days 4 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Dixon
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Ella Bantum
15. Birthplace Balto. Md

16 (a) Informant Mary Parks (sis)
(b) Address 449 Walton Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-31-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md

18 (a) Funeral director Chas. Cook Co.
(b) Address 5127 Carrollton Ave

19 (a) JAN 29 1947 (Date received by Registrar) Huntington Ave Williams, Mortician

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-27 1947 at 3:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 20 1946 to Jan 27 1947 and that I last saw him alive on 1/27 1947

Immediate cause of death: Acute Myocarditis — 7 Days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. J. Stakem M. D.
Address 1115 Park Ave Date signed 1/29/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48021

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13/a

G48021 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4302 Dewey Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 80yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4302 Dewey Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Margaret R. Waters

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | C | Widowed |

6 (b) Name of husband or wife Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/4/1860

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 86 | 9 10 | 21 | hr. min. |

9. Birthplace Easton, Md.
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Edward Thomas
13. Birthplace Md.

MOTHER
14. Maiden Name Nancy
15. Birthplace Md

16 (a) Informant Louise Kirby (SIster)
(b) Address 1566 N. Fremont Ave

17 (a) Burial (b) Date thereof 1/29/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-512 N. Carrollton Ave

19 JAN 29 1947 Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/25/47 19 at 7. A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/15 19 47 to 1/25 19 47.
and that I last saw h[illegible] alive on 1/23 19 47.

Immediate cause of death
Cerebral Cardiac Vascular Disease - Hypertension — Duration 1 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify kind of place)
(e) Means of injury
23. Signature H. Williams M.D.
Address 510 N. Carrollton Ave Date signed 1/29/47

VS 150

G48022

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1318

Registered No. G48022

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Stud city
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs. 10
(e) Length of stay in Baltimore (yrs., mos., or days) ?

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** Elizabeth Wangen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | widowed |

6 (b) Name of husband or wife Henry Wangen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1862

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 84 5 | 6 | 20 | hr. min. |

9. Birthplace New Jersey — U. S. A. (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER 12. Name Fredrick Imhoff
13. Birthplace Germany

MOTHER 14. Maiden Name Frances Yenk
15. Birthplace Germany

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Stud city

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 30 1947 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 E. Biddle St

19 (a) JAN 29 1947 (City Registrar) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan - 28 - 1947, at 7 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 1 - 1947, to Jan 28 - 1947, and that I last saw her alive on Jan 27 - 1947

| Immediate cause of death | Duration |
|---|---|
| Edema Lungs | 1 day |
| Due to Chronic myocarditis | 3 yrs |
| Due to | |
| Other Conditions Chronic Nephritis | 2 yrs |

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23. Signature** C. Gill Wahl M. D.
Address 1631 E. North Av Date signed 1/29/47

VS 3

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48023

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

Registered No. G48023

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 Barclay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** CARRIE PRICE

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife: Adam J.Price
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan.28-1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 11 | 30 29 | hr. min. |

9. Birthplace: Somerset Co. Md.
(Town, county, and state)
10. Usual Occupation: Housework
11. Industry or business

FATHER
12. Name: John Carter White
13. Birthplace: Va.

MOTHER
14. Maiden Name: Muir
15. Birthplace: Somerset Co. Md.

16 (a) Informant: Otis L.Price
(b) Address: Hampton, Va.

17 (a) Burial (b) Date thereof Jan.30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Fairbanks Church Cem.
Location: Fairbanks, Md.

18 (a) Funeral director: John A. Miller
(b) Address: 234 Jefferson St.

Date received: JAN 29 1947 (b) Signature of Registrar: Walter Williams

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/27/ 1947 at 2 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/24 1947 to 1/27 1947 and that I last saw HER alive on 1/27 1947

| | Duration |
|---|---|
| Immediate cause of death: HEART FAILURE | |
| Due to: ARTERIOSCLEROTIC HEART DISEASE | |
| Due to: | |
| Other Conditions: DIABETES MELLITUS | |

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Albert Gerbstein M.D.
Address: 3706 Rosedale Rd. Date signed: 1/27/47

937

C48024
CWK-107819

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 47c

Registered No. C48034

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Meryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 509 N. Enaor Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Jerry Brown

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 3-1905

8. AGE: Years 41 | Months 4 | Days 23 | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace

MOTHER
14. Maiden Name Not Known
15. Birthplace

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/30/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County, Md.

18 (a) Funeral director Joseph B. Locke
(b) Address 1304 E. Eastern Ave

JAN 29 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Janiaury 26 1947, at 1:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 22 1947, to Jan. 26 1947, and that I last saw h im alive on Jan. 26 1947.

Immediate cause of death: Respiratory Failure — Duration
Due to: Pulmonary Embolism
Due to: Hypertensive Heart Disease
Other Conditions: Arteriosclerosis, Heart Failure
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Same as above plus early bronchopneumonia
of autopsy: Chas Carstrom, Lt. Coroner

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. L. Scarborough M. D.
Address Balto City Hosp. Date signed 1-29-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48025

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G48025 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 709 N. Spring St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 18yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 709 N Spring St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Booker

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Burke Booker
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) May 2 1887

8. AGE: Years 57 | Months 8 | Days | If less than one day hr. min.

9. Birthplace Cumberland Va
(Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Joseph Hendrick
13. Birthplace Cumberland, Va

MOTHER
14. Maiden Name Unknown
15. Birthplace Va

16 (a) Informant Pearl B. Pleasant
(b) Address 709 N. Spring St

17 (a) Burial (b) Date of burial, cremation, or removal 1/29/47
(month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Robert L. Crowcroft
(b) Address 1216 W. Baltimore St

19 (a) JAN 28 1947 [illegible] Williamson, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 1947 at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 18 1946 to Jan 28 1947 and that I last saw he alive on Jan 25 1947

| Immediate cause of death | Duration |
|---|---|
| mitral insufficiency | |
| Due to Diabetes mellitus | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Edward Fisher
Address 1612 Monument Date signed 1/30/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48026

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. G48026

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2926 Arlington ave - residence
(c) Hospital or institution: Community Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balt
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2926 Arlington ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Frank G Ashburn

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Theresa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 25-1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | 10 | 2 | hr. min. |

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Led repairman
11. Industry or business

FATHER
12. Name griffin Ashburn
13. Birthplace Va

MOTHER
14. Maiden Name Emma Reeds
15. Birthplace Va

16 (a) Informant Mrs. Theresa Ashburn
(b) Address 2926 Arlington Ave.
17 (a) Burial (b) Date thereof 1/30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland
Location Baltimore
18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Rd.
19 (a) 1/24/47 (b)
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/27 1947, at 7 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 1/23/47 1947, to 1/27 1947, and that I last saw h[illegible] alive on 1/27 1947

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Chronic nephritis | |
| Due to arteriosclerosis | |
| Other Conditions Hypertension | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cameron Nichols M.D.
Address Univ. Hosp Date signed 1/28/47

VS 150

G48027

G48027

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 194a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) deaa
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3412 Harford Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Patrick J. Connolly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Stella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5 - 1891

8. AGE: Years 56 | Months 0 | Days 23 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Motorman

11. Industry or business B.T.Co.

FATHER 12. Name Michael Connolly

13. Birthplace

MOTHER 14. Maiden Name Sarah Reilly

15. Birthplace

16 (a) Informant Mrs. Mary S. Connolly

(b) Address 3412 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto. Md.

18 (a) Funeral director Leonard A. Ruck

(b) Address 5305 Harford Rd.

19 (a) 1/31/47 (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan. 28th 1947, at 5 30 P.M

**21.** I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Walden M.D. (Medical Examiner.)

Date signed 1-28-47

VS 181

G48028

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 42

Registered No. G48028

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4324 Sheldon Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mr. Gustavus H. Ward (GUSTAVUS HEIBEL WARD)

3 (b) If veteran, name war: 1st World War
3 (c) Social Security Account No.: None

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | married |

6 (b) Name of husband or wife: Loretta S. Ward
6 (c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): Mar 21 1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | 10 | 24? | hr. min. |

9. Birthplace: Pennsylvania (town, county, and state)
10. Usual Occupation: Deputy (U.S. Marshall)
11. Industry or business: Civil service

FATHER
12. Name: Samuel O. Ward
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Ida M. Heibel
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mrs. Loretta S. Ward
(b) Address: 4324 Sheldon Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-31-47 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC
(b) Address: NORTH AVE. & BROADWAY

19 (a) JAN 29 1947 (Date rec'd by registrar) (b) Thurlington Williams M.D. (Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Jan 28 1947, at 3 40 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 27 1947 to Jan 28 1947, and that I last saw him alive on Jan 28 1947

| Immediate cause of death | Duration |
|---|---|
| Amyotrophic Lateral Sclerosis | 4 yrs. |
| Due to | |
| Due to | |
| Other Conditions: Hypertensive cardiovascular disease | |

(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature: Norman R. Freeman Jr. M.D.
Address: Union Memorial Hosp. Date signed: Jan 28 '47

VS 150

X

G48029

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1939

Registered No. G48029

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2034 E. Eager Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2034 E. Eager Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ELSIE MARGARET WISEMAN

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William J. Wiseman
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1886

8. AGE: Years 60 | Months 3 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John A. Diver
13. Birthplace RedBank N. J.

MOTHER
14. Maiden Name Mary Oertel
15. Birthplace Germany

16 (a) Informant Mr. William J. Wiseman
(b) Address 2034 E. Eager Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/ 29/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) JAN 29 1947 (Date rec'd by registrar) Huntington Williams M.D.

**MEDICAL CERTIFICATION** PM

20. DATE OF DEATH January 26 1947, at 11.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1945, to Jan 26 1947, and that I last saw h.m. alive on Jan 23 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | |
| Due to Essential Hypertension | |
| Due to | |
| Other Conditions Hypertension Cardio-Vascular disease | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lemuel Britt M. D.
Address 1221 N. Luzerne Ave Date signed 1/27/47

VS 150

X

G48030

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93c

Registered No. G48030

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: So Balto Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6710 Bessemer Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lloyd R. Fairfield (LLOYD REES FAIRFIELD)

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 213-09-4333

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ruth Fairfield
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) 5/27/03

8. AGE: Years 43 | Months 8 | Days 1 | If less than one day: hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation Steel worker

11. Industry or business Bethlehem Steel

FATHER
12. Name George R Fairfield
13. Birthplace Pa.

MOTHER
14. Maiden Name Amy Reese
15. Birthplace Pa.

16 (a) Informant Mrs. Ruth A. Fairfield
(b) Address 6710 Bessemer Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-31-47 (month) (day) (year)
(c) Cemetery or crematory OAKLAWN CEMETERY
Location BALTIMORE, MARYLAND

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) JAN 29 1947 (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/28 1947 at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/19 1947, to 1/28 1947, and that I last saw h[illegible] alive on 1/18 1947.

Immediate cause of death: Pulmonary edema — Duration:
Due to: Rheumatic carditis — Duration:
Due to: Valvular disease — Duration:
Due to — Duration:
Other Conditions — Duration:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O. Eareckson M. D.
Address Sx Balto Harbor Date signed 1/28/47

VS 150

G48031

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G48031

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 203 Dickman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 203 Dickman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Thomas S. Nelson

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife Nettie May Myers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/6/1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 7 | 21 | hr. min. |

9. Birthplace Tenn. (Town, county, and state)
10. Usual Occupation Motorman, B.T.C.
11. Industry or business

FATHER
12. Name John F. Nelson
13. Birthplace Tenn.

MOTHER
14. Maiden Name Julia ?
15. Birthplace Tenn.

16 (a) Informant Family
(b) Address 203 Dickman ST.

17 (a) B (Burial, cremation, or removal) (b) Date thereof I/30/47 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glenburnie, Md.

18 (a) Funeral director James L. McCarthy
(b) Address 420 E. Fort Ave.

19 JAN 29 1947 (Date rec'd by registrar) Huntington Willis, M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 1-27-47 19 at 7:00 P. M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 1-1-46 19 to 1-27-47 19, and that I last saw him alive on 1-27-47 19

Immediate cause of death Terminal Bronchopneumonia — Duration 2 hrs.

Due to Arteriosclerosis — Duration 2 yrs.

Due to Senility — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. V. Pangle

Address 642 North Bl.d Date signed 1-29-47 M. D.

R. V. Pangle M.D.

G48032 A 52680 BALTIMORE CITY HEALTH DEPARTMENT X G48032
# CERTIFICATE OF DEATH V 157E
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Fredericksburg (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Edward Dickinson

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| — | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | — |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 - 8 - 46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 1 mo | 20 | hr. min. |

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business —

| | |
|---|---|
| FATHER | 12. Name Wm. Dickinson |
| | 13. Birthplace Va. |
| MOTHER | 14. Maiden Name Peggy Shellings |
| | 15. Birthplace Va. |

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Removal (b) Date thereof Jan 29 47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Fredericksburg Va.
18 (a) Funeral director Wm. P. Dickinson & Sons
(b) Address North & Penna. Ave Baltimore Md
19 (a) (b)

Filed JAN 29 1947 Registrar

**MEDICAL CERTIFICATION** P.

20. DATE OF DEATH Jan. 28 1947 at 6.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1947 to Jan 28 1947 and that I last saw him alive on Jan 28 1947

| Immediate cause of death | Duration |
|---|---|
| Operation - Arteriosclerosis Pulmonary Vein to Superior Vena Cava | 10 hrs. |
| Due to Cong. Heart - Transposition great vessels | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation Jan 28 1947
Major findings of operation: Arteriosclerosis Pulmonary Vein to Superior Vena Cava
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. B. Scruggs M. D.
Address Johns Hopkins Hospital Date signed 1-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48033

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 186a

G48033 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard + Madison Sts.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 54 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3809 Dorchester Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Miss Ida V. Orem

3 (b) If veteran, name war

3 (c) Social Security Account No. No

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 28 1870

8. AGE: Years 77 | Months — | Days — | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Vincent N. Orem
13. Birthplace Md

MOTHER 14. Maiden Name Harriett E Neal
15. Birthplace Md

16 (a) Informant Thomas Undefined
(b) Address 3808 Dorchester Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 30 47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore

18 (a) Funeral director Frank H. Seth
(b) Address 814 Hamilton Williams, Md.

19 JAN 29 1947 (Date received by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-28 1947, at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-9 1946 to 1-28 1947. and that I last saw h[illegible] alive on 1-28 1947.

Immediate cause of death Cardiac + respiratory failure, secondary to general debility — Duration

Due to fracture, intertrochanteric left femur

Due to Fall

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 11-9-46; 12-4-46

Major findings of operation: Fracture, left hip

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 75/10
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 11-9-46
(c) Where did injury occur? 3808 Dorchester Rd. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? —
(e) Means of injury Fell to floor

23. Signature Carlton Dupuis M. D.
Address Maryland General Hosp. Date signed 1-28-47

VS 150

For Dr. C. J. Zubrinski, by Howard J. Conaway, M.D. X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G48034

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 119a

Registered No. G48034

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood St.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 Days
(e) Length of stay in Baltimore (yrs., mos., or days) same

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Howard
(c) City or town Dayton
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rural
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Thomas Simpson

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| — | — |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | |

6 (b) Name of husband or wife NONE 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| — | 3 | 18 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Thomas Simpson

13. Birthplace Md.

14. Maiden Name Viola Hobbs

15. Birthplace Virginia

16 (a) Informant mother

(b) Address

17 (a) Burial (b) Date thereof 1-31-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Smithsonia
Location Catonsville Md

18 (a) Funeral director H. C. Hig undertaker

(b) Address Ellicott City Md

19 (a) JAN 29 1947 Huntington Williams, Mgr.
(Signature of registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-28 1947 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25 1947 to 1-28 1947
and that I last saw h[illegible] alive on 1-28 1947

Immediate cause of death accidents — Duration

Due to Infectious Diarrhea

Due to

Other Conditions Hare lip, cleft palate.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Workman M.D.
Address Univ. Hosp. Date signed 1-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C48035

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 168

Registered No. C48035

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1155 E. Lombard Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Thelma Ross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1917

8. AGE: Years 29 | Months 2 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation General Housework

11. Industry or business

FATHER
12. Name George Ross
13. Birthplace Dorchester Co. Md.

MOTHER
14. Maiden Name Alice Milbourne
15. Birthplace Maryland

16 (a) Informant Josephine Scott
(b) Address 112 Madeira St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/29/47 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill, Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) JAN 29 1947 (Date received by Registrar) Huntington Williams (Registrar)

VS 151

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** January 23, 1947 at 9:30 P. M.

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock and Hemorrhage, external hemorrhage

Due to

Other Conditions Multiple lacerations, abrasions, brush burns, bruises
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/23/47 at 9 P. M.
(b) Where did injury occur? 1155 E. Lombard Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Blunt Force

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 1/24/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48036

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G48036

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Sts
(c) Hospital or institution: Maryland General Hospital No
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) [illegible] Maryland
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2580 W. Fayette St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mamie Dorzon

3 (b) If veteran, name war: No.
3 (c) Social Security Account No. 217-05-3678

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Edgar Leroy
6 (c) If alive, give age: 0 years

7. Birth date of deceased (mo., day, yr.): Oct. 22-1891

8. AGE: Years: 55 | Months: 3 | Days: 5 | If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: ?

11. Industry or business: Hopkins O.

FATHER
12. Name: Eudoxio Zuniguez
13. Birthplace: Baltimore Md

MOTHER
14. Maiden Name: Eulalio Zuniguez
15. Birthplace: Baltimore Md

16 (a) Informant: Edgar L. Dorzon
(b) Address: 2580 W Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan 30-47 (month) (day) (year)
(c) Cemetery or crematory: Chesterlee Cemetery
Location: Baltimore Md

18 (a) Funeral director: F. D. Kilpatrick & Son
(b) Address: 1500 Eutaw Place

19 (a) JAN 29 1947 Registrar: Huntington Williams M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Jan. 27th 1947, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9th 1947 to Jan 27th 1947 and that I last saw h[illegible] alive on Jan 27th 1947.

| Immediate cause of death | Duration |
|---|---|
| Auricular fibrillation | |
| Due to: C.V. Disease & Pneumonia | |
| Due to: Coronary disease | 18 days |
| Other Conditions: Laceration of right leg due embolism. | |

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: C. E. Gonzalez M. D.
Address: Maryland Gen. Hosp. Date signed 1/27/47

X

G48037 BC# G61974

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH √106c

Registered No. G48037

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Caton & Wickham Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) yr
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 S. Loudon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Sharon Arnold

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/2/46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 2 | 28 | hr. min. |

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation none - baby.

11. Industry or business

FATHER 12. Name Clarence Arnold
13. Birthplace Maryland

MOTHER 14. Maiden Name Dorothea Brannan
15. Birthplace Penna

16 (a) Informant Mrs. Dorothea K. Arnold
(b) Address 207 S. London Ave.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Feb. 1-47. (Month) (day) (year)

(c) Cemetery or crematory Meadow Ridge Cem.
Location

18 (a) Funeral director Charles J. Schwab.
(b) Address 3512 Frederick Ave.

JAN 29 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 1/29 1947, at 7:30 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 1/25 1947 to 1/29 1947 and that I last saw he alive on 1/29 1947

Immediate cause of death
Bronchopneumonia — Duration

Due to Coryza-tracheo-bronchitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1-26-47

Major findings of operation: Tracheo-bronchitis

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23.** Signature Henry W. Hollges M. D.
Address St. Agnes Hospital Date signed 1-29-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48038

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G48038 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1838 W. Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1838 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME R. R. EDWARD BADING.

3 (b) If veteran, name war None | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Ruth M. Bading
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19-1879.

8. AGE: Years 67 | Months 8 | Days 18 | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Machinist.

11. Industry or business

FATHER
12. Name Fritz Bading.
13. Birthplace Germany.

MOTHER
14. Maiden Name Sophie Weiss.
15. Birthplace Germany.

16 (a) Informant Mrs. Ruth M. Bading.
(b) Address 1838 W. Fayette St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Jan. 30-47. (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery.
Location Woodlawn Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 3512 Frederick Ave.

19 (a) JAN 29 1947 (Date rec'd by registrar) (b) Hunter for Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 27 1947, at 9.10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 22 1946, to Jan 27 1947, and that I last saw h[illegible] alive on Jan 27 1947

Immediate cause of death: Cardiac Failure. — Duration

Due to: Cardio-Vascular Disease.

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Elliott Seagrott M. D.
Address 1229 W. Lombard St Date signed 1/28/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48039

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G48039

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1522 John St.
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1522 JOHN ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** JAMES - E. COLLEY.

3 (b) If veteran, name war: None.

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Lottie M. Colley.

6 (c) If alive, give age: 0 years

7. Birth date of deceased (mo., day, yr.): March 11 - 1886

8. AGE: Years: 60 | Months: 10 | Days: 15 | If less than one day: hr. min.

9. Birthplace: Baltimore - Md.
(Town, county, and state)

10. Usual Occupation: Machinist.

11. Industry or business

FATHER — 12. Name: James A. Colley.
13. Birthplace: Md.

MOTHER — 14. Maiden Name: Ida May Umpstead.
15. Birthplace: Md.

16 (a) Informant: Mrs. Lottie M. Colley.
(b) Address: 1522 John St.

17 (a) Burial. (b) Date thereof: Jan. 30-47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Western Cemetery.
Location: Baltimore - Md.

18 (a) Funeral director: Charles J. Schwab.
(b) Address: 3512 Frederick Ave.

19 (a) JAN 29 1947 Hamilton Williams, M.D.
(Date received) (Registrar)

VS 199

## MEDICAL CERTIFICATION

20. DATE OF DEATH JAN 26, 1947, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from MAR 29 1946 to JAN 26, 1947. and that I last saw h.IM. alive on JAN 26 1947.

| Immediate cause of death | Duration |
|---|---|
| A. CORONARY thrombosis | |
| Due to HYPERTENSIVE — ARTERIOSCLEROTIC CVHD | |
| Due to CEREBRAL AND GENERALIZED ARTERIOSCLEROSIS | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Willard Appenfeldt M. D.

Address 2511 Reisterstown Rd Date signed 1/29/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48040

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 163H

Registered No. G45020

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1803 N. Port Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Annie Thompson Thomas

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, ~~widowed~~, or ~~divorced~~. |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 17th 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 74 | 10 | 10 | hr. min. |

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Adam Thomas
13. Birthplace Germany

MOTHER
14. Maiden Name Christine
15. Birthplace Germany

16 (a) Informant Elmer Thomas
(b) Address 1803 N. Port St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 31st 1947 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Leo V. Jacobs
(b) Address 1701-03 N. Patterson Park Ave

19 (a) JAN 29 1947 [illegible]

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/27/47 19 , at 11:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Carbon Monoxide Poisoning

Due to Gas from 4 burner Kitchen stove burners

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/27/47 10:00 P.M.
(b) Where did injury occur? Home
(c) Did injury occur at home, on farm, industrial place, in public place? 1803 N. Port Street While at work? No
(d) Means of injury Self Inflicted

23. Signature John R. Sairs M.D.
Medical Examiner.
Date signed 1/28/47

Lennah F. Lee

G18011

BALTIMORE CITY HEALTH DEPARTMENT X

# CERTIFICATE OF DEATH 186a

Registered No. G18011

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution Sin. Balto Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Anne Arundel
(c) City or town Brooklyn Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ft Smallwood Rd. Parkton, Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lennah F. Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced M.

6 (b) Name of husband or wife Charles Lee
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) 10-31-1884

8. AGE: Years 62 | Months 2 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name WILLIAM STEWART
13. Birthplace VIRGINIA

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace VIRGINIA

16 (a) Informant AMY LEE
(b) Address FORT SMALLWOOD RD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1 31 47 (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL
Location ANNAPOLIS BLVD.

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT St.

19 (a) JAN 29 1947 Thos. Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-25 1947 at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-18 1947 to 1-25 1947 and that I last saw h[illegible] alive on 1-29 1947

Immediate cause of death: Acute coronary occlusion — Duration

Due to

Due to

Other Conditions Fract. dislocation Left ankle.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 2. 9. 6.
(a) Accident, suicide, or homicide Accidental
(b) Date of occurrence 1-13-47 at 2 P M
(c) Where did injury occur? Ft. Smallwood Rd. Parkton (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Fell down cellar steps

23. Signature Howard J. Mercer, M.D. X

Address 1213 Light St. Date signed 1-27-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18012

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1179

Registered No. 18012

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 820 Woodyear (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** FRANK SCOTT.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | N | M |

6 (b) Name of husband or wife Katie C. Scott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886 (1874)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 (72) | | | hr. min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Katie C. Scott
(b) Address 820 Woodyear Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 29, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mr. Katie R. Williams
(b) Address 322 W. Lanvale St

19 JAN 29 1947 (b) Katie R. Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 26 Jan 1947 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 26 Jan 1947 to 26 Jan 1947 and that I last saw h[illegible] alive on 26 Jan 1947

Immediate cause of death Shock — Duration 6 hrs

Due to Possible perforated peptic ulcer -

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James R. Harris M. D.
Address University Hosp. Date signed 26 Jan 47

VS 130

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C48013

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 56c

C48013 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Oliver & Caroline Sts
(c) Hospital or institution St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2947 Clifton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs Fannie A Lilly

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widow |

6 (b) Name of husband or wife John F. Lilly
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 8 | 18 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Francis Bibleheiser
13. Birthplace

MOTHER
14. Maiden Name Ellen Morrow
15. Birthplace Baltimore, Md.

16 (a) Informant Adell Beck
(b) Address 2616 Fairmount Ave.

17 (a) Burial (b) Date thereof Jan. 30. 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location

18 (a) Funeral director Frank V. Pipitone
(b) Address 2815 E. Baltimore St.

19 JAN 29 1947 Williamsport, Md.
(Date rec'd by registrar) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1947 at 12 Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1947, to Jan 27 1947, and that I last saw deceased alive on Jan 27 1947

| Immediate cause of death | Duration |
|---|---|
| Cardio respiratory failure | |
| Due to Hypertensive Cardio-vascular Disease | |
| Due to | |
| Other Conditions Diabetes Mellitus | |

(Include pregnancy within 3 months of death)
Date of operation Jan 8, 1947
Major findings of operation: Cervical Polyp. Related Vaginal outlet
If autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John B. Walls M.D.
Address Johns Hop Date signed 1-27-47

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

G48014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G48014

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2001 Maryland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Mitchell Evans

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Phoebe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/8/59

8. AGE: Years 87 88 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual Occupation: Seaman

11. Industry or business

FATHER
12. Name: Solomon L. Evans
13. Birthplace: Md.

MOTHER
14. Maiden Name: Ruth Marshall
15. Birthplace: Md.

16 (a) Informant: Edward Evans (Son)
(b) Address: 2001 Maryland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 31, 1947 (month) (day) (year)
(c) Cemetery or crematory: Lowe Cemetery
Location: Lowe, Smith Island, Md.

18 (a) Funeral director: H. Harvey Brasefield
(b) Address: Crisfield, Md.

19 (a) Filed JAN 29 1947 (b) Registrar

VS 151

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan. 29, 1947, at 10 A.M.

**21.** I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

**23.** Signature Howard J. Mullen, M.D.
Medical Examiner.
Date signed 1/29/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48015

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 180

G48015 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 209
(e) Length of stay in Baltimore (yrs., mos., or days)

2. ~~USUAL RESIDENCE OF DECEASED~~: Temporary residence of deceased:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Altamont Hotel, Eutaw & Lanvale
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Stovall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years 36 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace
(town, county, and state)

10. Usual Occupation Soldier

11. Industry or business U.S.A

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Camp Holabird
(b) Address Balto Md

17 (a) Burial, cremation, or removal (b) Date thereof January 29-1947 (month) (day) (year)

(c) Cemetery or crematory SPARTA, TENN
Location TENN.

18 (a) Funeral director Lillye Zeller INC
(b) Address 407 S. Wolfe St

JAN 29 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 26 19 47, at 2:25 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull, Intracranial hemorrhage Laceration of brain, Broken neck

Due to Fractured first left rib and upper breast plate

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-26-47 at 2:15 11/4 a M.
(b) Where did injury occur? Eutaw & Lanvale Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Jumped from 3rd floor window Struck by a fall in room.

23. Signature [illegible] Medical Examiner. M.D.

Date signed 1-27-47

Death Certificate

G48076 G-68848

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1611 Fairmore G48076 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 2

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. St. Joseph's Hosp. (If rural give location)
(e) Citizen of foreign country? Habitually Place (Yes or No)
If yes, name country

**3 (a) FULL NAME** Jennie Irene Lemmore

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 23 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 3 | hr. min. |

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Dan Lemmore
13. Birthplace Balto Md

MOTHER
14. Maiden Name Irene Smith
15. Birthplace Balto. Md.

16 (a) Informant Mother
(b) Address 1611 Hokesby Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/30/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltby

18 (a) Funeral director J. J. Rupk
(b) Address 5305 Harford Rd

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 29 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1947 at 1:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 1947 to Jan 27 1947 and that I last saw h.e.r alive on Jan 26 1947

Immediate cause of death: Cardiac Respiratory Failure — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Massive Hemorrhage of Bronchial Tube

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry J. Wilson M.D.
Address St. Joseph's Hosp Date signed 2 Jan 47

X

G48017

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G48017 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5 1/2
(c) Hospital or institution: Sinai Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1725 Cole Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** HARRY George STAUFFER

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| None | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Louise Eleanora Stauffer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 10 | 5 4 | hr. min. |

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Hard Wood Utility Worker
11. Industry or business Retired

FATHER
12. Name George F. Stauffer
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Henrietta Cornthwaite
15. Birthplace Balto. Md.

16 (a) Informant John E. Stauffer
(b) Address 30 E Kingston Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 31 - 1947 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director George L. Aglewat
(b) Address 2101 Frederick Ave.

Filed 1-29 1947 (b) Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 1/28 1947, at 10 30 AM

**21.** I certify that death occurred on the date above stated; that I attended deceased from 1/27 1947, to 1/28 1947, and that I last saw h[illegible] alive on 1/28 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23. Signature** S M Yaffe M. D.
Address Sinai Hosp. Date signed 1/28/47

VS 150

G48048

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G48048

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1808 N. Caroline Dvt. St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 N. Caroline St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Cora Royston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) ~~Single, married, widowed, or divorced.~~ Widowed

6 (b) Name of husband or wife: John S. Royston

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 12th 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 5 | 16 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert H. Proctor
13. Birthplace Balto Co. Md.

MOTHER
14. Maiden Name Susanna Atchison
15. Birthplace Prince George Co. Md.

16 (a) Informant Ida F. Miller
(b) Address 1808 N. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1247 E. Paul St.

19 (a) JAN 30 1947 (Date rec'd by registrar) (b) Filed Washington Williamsport, Md.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/28 1947 at 7:24 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. L. Lubrinski M.D.
Medical Examiner.
Date signed 1/30/47

VS 151

G48049

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 150

Registered No. G48049

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3925 Canterbury Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 - 1
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3925 Canterbury Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Annie Elizabeth Wilhide

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | married |

6 (b) Name of husband or ~~wife~~ Claude W. Wilhide
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 6 | 4 | hr. min. |

9. Birthplace Frederick, Md.
(Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business Home

FATHER
12. Name Thomas S. Eader
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name Catharine Rebecca Ramsburg
15. Birthplace Frederick, Md.

16 (a) Informant Mr. Claude W. Wilhide
(b) Address 3925 Canterbury Road

17 (a) Burial (b) Date thereof 1/31/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Frederick Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 JAN 30 1947 (b) Huntington Williams M.D.
(Date received) Registrar

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** January 28 1947, at 9:15 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from August 1946, to January 28 1947, and that I last saw her alive on Jan. 28 1947

Immediate cause of death: Carcinoma of Breast — Duration 2 1/2 yrs
c Metastases to lungs & bones — 1 year
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Sept 24 1946
Major findings of operation: Carcinoma of left breast & involvement of axillary glands
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Francis W. Gluck M. D.
Address 715 Park Ave Date signed 1/29/47

X

G48050

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G48050

1-218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 ds
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Belt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 207 Cedarcroft Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Dorothy Lillian Lobell

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife James V. Lobell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8th 1891

| 8. AGE: Years | Months | Days | If less than one day: hr. | min. |
|---|---|---|---|---|
| 55 | 8 | 21 | | |

9. Birthplace Orange, N. J.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name Theodore Vincenty
13. Birthplace N. J.

MOTHER — 14. Maiden Name Emma Gamble
15. Birthplace N. J.

16 (a) Informant James V. Lobell
(b) Address 207 Cedarcroft Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) JAN 30 1947 (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 29 1947 at 1:42 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20, 1947 to Jan 29, 1947 and that I last saw h. alive on Jan 29, 1947.

Immediate cause of death Myocardio-Resp. failure — Duration

Due to Uremia, Pericarditis

Due to Chronic Glomerular Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Erwin R. Jennings M.D.

Address Date signed 1/30/47

VS 150

PG 18051

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. 018051

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days) Whole

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3557 Brehm Vista Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary A. Wilhelm (Also known as) Bell Wilhelm

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, ~~married, widowed, or divorced~~ |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 11 1864

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | 8 | 17 | hr. min. |

9. Birthplace Balto. Co. Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Frey Wilhelm
13. Birthplace Balt. Co. Md.

MOTHER
14. Maiden Name Sarah E. Daugherty
15. Birthplace Balto. Co. Md.

16 (a) Informant Sara E. Bollinger
(b) Address 321 E. 33rd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/1/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Zion
Location Freeland Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 JAN 30 1947 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29th 1947, 11a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1947 to Jan 29 1947, and that I last saw ~~him~~ her alive on Jan 29 1947.

| Immediate cause of death | Duration |
|---|---|
| General arterial sclerosis | 5 yrs |
| Cerebral Hemorrhage | 6 days |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Melvin L. Solomon
Address 149 S. Broadway Date signed 1/29/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48052

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G48052

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 801 S. Charles St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-2-11
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 801 S. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William J. McDonald

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Florence Wade

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17th 1864

8. AGE: Years 82 Months 9 Days 10 If less than one day hr. min.

9. Birthplace Mass. (Town, county, and state)

10. Usual Occupation Printer

11. Industry or business

FATHER
12. Name Cyrus MacDonald
13. Birthplace Scotland

MOTHER
14. Maiden Name Eugenia (Unknown)
15. Birthplace Scotland

16 (a) Informant Mrs Ada Kennedy
(b) Address 1120 Darley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/30/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) JAN 30 1947 (Date rec'd by registrar) (b) Funeral Director for Williams, M.D.

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27, 1947, at 9 a. M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiac - Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Williams M.D. Medical Examiner.
Date signed 1-27-47

G18053

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. G18053

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 12 D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Brevard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William ARTHUR JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Married |

6 (b) Name of husband or wife Alice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 3, 1892

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 | 9 | 28 | hr. min. |

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER
12. Name Wm. A. Johnson Sr.
13. Birthplace Marion S.C.

MOTHER
14. Maiden Name Unknown
15. Birthplace ?

16 (a) Informant Alice Johnson
(b) Address 1206 Brevard St.

17 (a) Burial (b) Date thereof 1/31/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill, Md.

18 (a) Funeral director E. Halstead
(b) Address 918 Druid Hill Ave

19 (a) (b) Huntington Williams, M.D.

JAN 30 1947

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan. 28, 1947, at 1.30 P.M.

**21.** I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary occlusion
Hypertrophy & dilatation and chr. valvulitis of heart; Generalized arteriosclerosis
Atheronephrosclerosis
Edema of brain
Other conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Williams M.D.
Medical Examiner.
Date signed 1-29-47

G48054 Birth Certificate D.68955

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

161c

Registered No. G48054

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument St.& Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Anne Arundel
(c) City or town Glen Burnie (If outside city or town limits, write RURAL and give town)
(d) Street No. Light Street Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Samm

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1947

8. AGE: Years 0 | Months 0 | Days 0 | If less than one day 14 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John C. Samm
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Amelia Hoffnakle
15. Birthplace Baltimore, Md

16 (a) Informant John C. Samm
(b) Address Glen Burnie, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 30, 194 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

19 JAN 30 1947 (Date rec'd by Registrar) (b) [illegible] Millersville, Md.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-29-47 19 at 2 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-28 1947 to 1-29 1947, and that I last saw h.21 alive on 1-29 1947

Immediate cause of death: Resp. Failure — Duration:

Due to Adrenal Hemorrhage

Due to

Other Conditions Premature born

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy Adrenal Hemorrhage

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Morris L. Michael M.D. M. D.
Address Sinai Hosp. Balt. Date signed 1-29-47

VS 150

G48055

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G48055

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2316 Robb St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Mrs. Mary E. Thompson

3 (b) If veteran, name war: hs
3 (c) Social Security Account No.: hs

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife: Wm S. Thompson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 6 | 14 | hr. min. |

9. Birthplace Patterson N J (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Thomas Carroll
13. Birthplace Camden N J

MOTHER
14. Maiden Name Unknown
15. Birthplace Camden N J

16 (a) Informant Mrs Thompson
(b) Address 2316 Robb Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Edmondson Ave Balto Md

18 (a) Funeral director Albert L Walk & Co
(b) Address 1606 E Chester Street

19 (a) JAN 30 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1947, at 9:50 A M

21. I certify that I took charge of the remains described above, held an Inqu. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Weddell M.D. Medical Examiner.
Date signed 1-29-47

VS 181

G-18056
CWK-107994

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 55E

Registered No. G-18058 3-48056

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 73- 4- 0-

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1042 N. Central Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** C. Henry Heilman

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | 212-10-7816 |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widower |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29-1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73- | 4 | 0 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Order Clerk
11. Industry or business Wat. Enamel Stove Co.

FATHER
12. Name Not Known Friedrich Heilmann
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known Mary E. Eemmer
15. Birthplace Germany

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 1, 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location 4430 Belair Rd.

18 (a) Funeral director Edmund W. Conklin & Son
(b) Address 924 E. Eager St.

19 (a) JAN 30 1947 (b) [illegible]

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1947, at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 28 1947 to Jan. 29 1947, and that I last saw h im alive on Jan. 29 1947.

| Immediate cause of death | Duration |
|---|---|
| Arteriosclerotic Heart Disease with Acute Congestive failure | |
| Due to | |
| Due to | |
| Other Conditions Abdominal carcinomatosis, primary site unknown except (Include pregnancy within 3 months of death) | |
| Date of operation | |
| Major findings of operation: | |
| of autopsy: Abscess & gangrene - et leg | |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice M. Lacy, M.D. M. D.
Address Baltimore City Hospitals Date signed 1-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18057

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

G18057 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3105 WEAVER AVENUE
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-1
(e) Length of stay in Baltimore (yrs., mos., or days) 88 YRS.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town BALTIMORE, 14 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3105 WEAVER ANE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

**3 (a) FULL NAME** MICHAEL HOFFMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M. | W. | WIDOWED |

6 (b) Name of husband or wife EMMA J. DONAHUE
6 (c) If alive, give age X years

7. Birth date of deceased (mo., day, yr.) 7 JANUARY, 1859

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 88 | 0 | 22 | hr. min. |

9. Birthplace BALTIMORE, Md. (Town, county, and state)
10. Usual Occupation TINNER (RETIRED)
11. Industry or business PENNA. R.R.

FATHER
12. Name MICHAEL HOFFMAN
13. Birthplace SCOTLAND

MOTHER
14. Maiden Name MARY ANN KIRK
15. Birthplace SCOTLAND

16 (a) Informant MAUD W. KENT
(b) Address 3570 WALBROOK AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 31, 1947 (month) (day) (year)
(c) Cemetery or crematory PARKWOOD
Location 3310 TAYLOR AVENUE

18 (a) Funeral director Walter Burke Bradley
(b) Address 1922 W. North Avenue

JAN 30 1947 (b) Hunter Williams, M.D.

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 29 JANUARY 1947, at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1947 to Jan 29 1947, and that I last saw h. alive on Jan 28 1947

Immediate cause of death: Chr. Myocarditis — Duration 1935
Due to: Chr. Interstitial Nephritis — Duration 1935
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Jas. W. Hoon, M. D.
Address 1623 W. North Ave. Date signed 1/29/47

VS 150

File G18058

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13B

Registered No. G18058

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 Lauren's St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Amos Harcum

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: ?

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Negro | Widowed |

6 (b) Name of husband or wife: Fannie Harcum
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 20 1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 5 | 7 | hr. min. |

9. Birthplace: Northumberland Co., Virginia (Town, county, and state)
10. Usual Occupation: Unemployed
11. Industry or business

FATHER
12. Name: David Harcum
13. Birthplace: Northumberland Co., Virginia

MOTHER
14. Maiden Name: Virginia Gustus
15. Birthplace: Northumberland Co., Virginia

16 (a) Informant: Clifton Harcum
(b) Address: 923 Harlem Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/47 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn
Location: Md.

18 (a) Funeral director: Geo. B. Kelson
(b) Address: 1303 Pressalman St.

19 (a) JAN 30 1947 (Date received by registrar) Hampton Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Jan 27 1947, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17 1946 to 1-27- 1947 and that I last saw him alive on Jan 27 1947.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Tuberculosis with Abscess Formation | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: The Abscess, bilateral spread

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. R. COASEY M. D.
Address 753 GEORGE ST. Date signed 1/28/47

VS 150

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48059

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

✓ G48059

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 78

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 791 George st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| FR | W | Widowed |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 / 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 2 | ? | hr. min. |

9. Birthplace Havre de Grace, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (b) Date thereof 3-1-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Union Methodist
Location Dorsford, Co, Md.

18 (a) Funeral director Henry W. Torrey & Sons
(b) Address Aberdeen, Maryland.

19 JAN 30 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/30 1947 at 2:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/20 1947 to 1/30 1947.
and that I last saw her alive on 1/28 1947.

| Immediate cause of death | Duration |
|---|---|
| Meningitis | |
| Due to Pneumonia? | 10 Days |
| Due to | |
| Other Conditions Uremia. | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Bamford M. D.
Address Bromwell Apts Date signed 1/30/47

G48060

BALTIMORE CITY HEALTH DEPARTMENT ✓

# CERTIFICATE OF DEATH 92a

G48060 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 769 Ramsay St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County ✓
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 769 Ramsay (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Henry Dolle

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 220-01-4471

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M. | W. | married |

6 (b) Name of husband or wife Augusta Boecker
6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) Nov 17 1861

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 85 | 2 | 12 | ..... hr. ..... min. |

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Funeral Director

FATHER
12. Name Lorenz Dolle
13. Birthplace Germany

MOTHER
14. Maiden Name Johanna Shaffer
15. Birthplace Germany

16 (a) Informant Stanley F Dolle
(b) Address 769 Ramsay St

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Feb 1 1947 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto, Md.

18 (a) Funeral director Henry W Jenkins Sons & Cullen Orchard Sts
(b) Address

19 (a) ..... (b) ..... (Date filed by registrar) Registrar

JAN 30 1947
VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-29 1947, at 4:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 1946 to Jan. 29 1947, and that I last saw h[illegible] alive on 1-29 1947.

Immediate cause of death Chronic passive congestion — Duration .....
Due to cardiac failure — .....
Due to ..... — ..... over
Other Conditions ..... — .....
(Include pregnancy within 3 months of death)
Date of operation ..... — .....
Major findings of operation: ..... — .....
of autopsy: ..... — .....

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature A. L. Ewald Jr. M. D.
Address 36 York Court 18 Date signed 1-30-47

A. L. Ewald, Jr. ×

Dr. Saylor
3902 Greenmount

G48061

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

12/a

G48061

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 400 Calvin Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-2

(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 400 Calvin Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Marie C. Sullivan

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | married |

6 (b) Name of husband or wife Malcolm W. Sulliva
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | 11 | 18 | hr. min. |

9. Birthplace Phila, Pa.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Joseph B. Powers
13. Birthplace ?

MOTHER
14. Maiden Name Margaret Dunn
15. Birthplace ?

16 (a) Informant Mr. Malcolm W. Sulliven
(b) Address 400 Calvin Avenue

17 (a) Burial (b) Date thereof 2/1/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Herford Road -14-

JAN 30 1947 (b)
(Date received by registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29th, 1947, at 2:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 27 JAN. 1947, to 29 JAN. 1947, and that I last saw h[illegible] alive on 28 JAN 1947.

Immediate cause of death: Cerebral hemorrhage with hemiplegia (left) — Duration: 1½ days
Due to: Hypertension, Cardio-vascular renal disease — ?
Due to:

Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lloyd E. Saylor M. D.
Address 3902 Greenmount Ave Date signed 29 JAN 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48062

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

166

Registered No. G48062

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 N. Eden Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Edith Parson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rev. John Parson

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) 10-15-1914

8. AGE: Years 32 | Months 3 | Days 12 | If less than one day hr. min.

9. Birthplace Portsmouth, Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Wright
13. Birthplace Va

MOTHER
14. Maiden Name Irene Jones
15. Birthplace Va.

16 (a) Informant Rev. John Parson
(b) Address 508 N. Eden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-30-1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley ave.

19 (a) JAN 30 1947 (Registrar's signature) Huntington Williams, M.D. Registrar

VS 181

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 27, 1947, at 6 55 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to Res death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Bullet wound of heart, aorta and lung.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/27/47 at 6 30 A. M.
(b) Where did injury occur? Ground 1610 Jefferson Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms

23. Signature Howard Mueller M.D.
Medical Examiner.
Date signed 1/28/47

G48063

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 108

Registered No. G48063

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 18+1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 809 Vine St (Rear)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ernest FIELDS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Martina Fields

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 29, 1912

8. AGE: Years 34 35 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore Maryland
(Town, county and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Fields
13. Birthplace Chestertown, Md.

MOTHER
14. Maiden Name Mary Nichols
15. Birthplace West River, Md.

16 (a) Informant Sophia Fields
(b) Address 623 N. Carrollton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 31, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 822 W. Lexington St.

19 JAN 30 1947 (Date received by registrar) (b) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 27 19 47, at 2:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar pneumonia, rt. lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 1/28/47

VS 151

BARROLL

G48064

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

Registered No. G48064

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts.
(c) Hospital or institution University Hospital
(d) Length of stay in hospital or inst., (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
Ward 2 Street No. 604 N. Carey St.
(If rural, give location)
(d) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Joseph Barroll

3 (b) If veteran, name war
(c) Social Security Account No. 705-05-2219

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | M |

6 (b) Name of husband or wife Gertrude Barroll
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 21, 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 4 | 7 | hr. min. |

9. Birthplace Balto. Md. (Town, county, and State)
10. Usual Occupation Train Porter
11. Industry or business

FATHER
12. Name James Barroll
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Howard Co. Md.

16 (a) Informant Gertrude Barroll
(b) Address 604 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 31, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Kate P. Williams
(b) Address 322 W. Lanvale St.

19 (a) JAN 30 1947 (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 28 1947, at 9:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 27 1947, to Jan 28 1947, and that I last saw him alive on Jan 28 1947.

Immediate cause of death Acute Dilatation of Heart

Due to Missing Cerebral Hemorrhage

Due to Generalized arterio-sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

| Duration |
|---|
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard J. Cronin M. D.
Address University Hosp. Date signed 1/28/47

VS 150

BCH

G48065 G63511

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 64

Registered No. G48065

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County.....
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 705 Pierce Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Theresa Tommie Lee Ellis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5 Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar. 28, 1946

8. AGE: Years | Months: 2 | Days: - | If less than one day: .....hr. .....min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Ellis
13. Birthplace Va.

MOTHER
14. Maiden Name Nellie Avery
15. Birthplace Balto. Md.

16 (a) Informant Nellie Avery
(b) Address 705 Pierce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 31 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 222 N. Schroeder St.

19 (a)..... (Date rec'd by registrar) (b)..... Registrar

VS 151

**MEDICAL CERTIFICATION** 30

20. DATE OF DEATH January 28, 1947, at 2 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Status thymicolymphaticus

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature George S. Merrill M.D.
Medical Examiner.
Date signed 1/29/47

G18066

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

116a

Registered No. G18066

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Timonium
(If outside city or town limits, write RURAL and give town)
(d) Street No. York Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John R. Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 3 | 20 | — hr. — min. |

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Agent

11. Industry or business P.R.R.

FATHER 12. Name John Kelly

13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Hession

15. Birthplace Md

16 (a) Informant Hospital Records

(b) Address

17 (a) Burial (b) Date thereof Jan. 1, 1947
(Burial, cremation, or removal) (Month) (day) (year)

(c) Cemetery or crematory St. Joseph's Catholic Cem.

Location Texas, Balto. Co., Md.

18 (a) Funeral director John Burns' Sons

(b) Address Towson, Maryland

19 JAN 30 1947 Huntington Williams
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 29, 1947 at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 22, 1947 to Jan. 29 1947, and that I last saw h alive on Jan. 27 1947.

Immediate cause of death Cardiac Arrest

Due to Acute Bronchitis, myocardial insufficiency

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

| Duration |
|---|
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin R. Jamison M. D.

Address Date signed

VS 150

X

G18067
A-107066

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13B

Registered No. G18067

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. & 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1900 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Marion J. Rusyczeuski

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25-1909

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 37 | 6 (4) | 3 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Raymond Rusyczeuski (D
13. Birthplace Poland

MOTHER
14. Maiden Name Stella or Stekla Brondak
15. Birthplace Poland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 1/31/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Parkville Hill Rd

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 1623 S. Broadway

19 (a) JAN 30 1947 (b)
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 28 1947 at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-24- 1946 to 1-28 1947, and that I last saw h- in alive on 1-28- 1947

Immediate cause of death Pulmonary Tuberculosis, Far-advanced — Duration ?

Due to — Duration

Due to — Duration

Other Conditions Intestinal Parasites — Duration 2 hrs.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Hunt M. D.
Address Baltimore City Hosp. Date signed 1-29-47

VS 150

Borden ✓

G18068 BALTIMORE CITY HEALTH DEPARTMENT G48068

# CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Edmondson Ave and Wilkens Ave
(c) Hospital or institution: St Agnes Hospital 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Eagen and Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Theresa Borden

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23 1867

| 8. AGE: Years | Months | Days | If less than one day: hr. min. |
|---|---|---|---|
| 87 | | | |

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?
13. Birthplace ?

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Theresa Badenja
(b) Address 412 N. Rosebank Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 1 47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Vernon P.O. Md

18 (a) Funeral director Selby & Zilch
JAN 30 1947 (b) 8. Eutaw St
(Date rec'd by registrar)

19 (a) (b)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/30 1947 at 7.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/7 1947 to 1/30 1947 and that I last saw h[illegible] alive on 1/30 1947

| | Duration |
|---|---|
| Immediate cause of death: Pneumonia, hypostatic, bilateral | 3 days |
| Due to: Gangrene, arteriosclerotic, right foot | 10 days |
| Due to: Hypertensive C.V. disease | 5 years? |
| Other Conditions: Senile dementia | C.S |

(Include pregnancy within 3 months of death)
Date of operation Jan. 25, 1947
Major findings of operation: Amputation, right leg, for gangrene, foot
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence S. Carman
Address St. Agnes Hospital Date signed M. D. 1/30/47

VS 150

C 18069

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. C 18069

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 328 N. Pulaski Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 328 N. Pulaski Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Thomas A. (Coop) Koop

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Anna

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 (82) | — | 19 | hr. min. |

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retire

11. Industry or business

FATHER
12. Name Henry Koop
13. Birthplace ?

MOTHER
14. Maiden Name Mary Hammer
15. Birthplace ?

16 (a) Informant Thomas (Coop) Koop
(b) Address 328 N. Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Old Frederick Rd

18 (a) Funeral director A. Rohde & Son
(b) Address 2327 Edmondson Ave.

19 (JAN 30 1947) Huntington Williams M.D.

VS 181

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 29, 1947, at 11 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Coron. Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walker M.D. (Medical Examiner.)
Date signed 1-30-47

X

G48070

Cook at St. Timothy's School, Catonsville, Md.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 171a

Registered No. G48070

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 Oxford Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lonnie Carter

3 (b) If veteran, name war unknown

3 (c) Social Security Account No. unknown

4. Sex: male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. unknown

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1918?

8. AGE: Years 28? Months Days If less than one day hr. min.

9. Birthplace unknown (Town, county, and state)

10. Usual Occupation cook

11. Industry or business

FATHER
12. Name unknown
13. Birthplace —

MOTHER
14. Maiden Name unknown
15. Birthplace —

16 (a) Informant Leroy Davis
(b) Address 2500 Madison ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Wm. L. Chatman Jr
(b) Address 1701 McCulloh St.

19 (a) JAN 30 1947 (registered) (Remington, Williams, MD)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 1947, at 5 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull, Intracranial hemorrhage

Due to

Other Conditions Lacerations, brush burns, bruises
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-22-47 at 2 P. M. 11/4
(b) Where did injury occur? MADISON Ave & BIDDLE St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by streetcar

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 1-23-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48071

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G48071

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2402 Maryland avenue
(c) Hospital or institution:

12-7

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2402 Maryland avenue
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** LOUIS A. TAYLOR

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Annie Schwarz Taylor
6 (c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): June 4, 1869

8. AGE: Years: 77 | Months: 7 | Days: 25 | If less than one day: ....hr. ....min.

9. Birthplace: Annapolis, Maryland (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business

FATHER
12. Name: John Taylor
13. Birthplace: Annapolis, Maryland

MOTHER
14. Maiden Name: Lucretia Wilcox
15. Birthplace: Annapolis, Maryland

16 (a) Informant: Mrs. B. Ruth Ritterman
(b) Address: 2402 Maryland avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 1/47 (month) (day) (year)
(c) Cemetery or crematory: Holy Cross
Location: A. A. Co. Md.

18 (a) Funeral director: Chas. J. Carnes Son
(b) Address: 119 W. Mt. Royal Ave

19 (a) JAN 30 1947 (Registrar) Huntington Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 29 1947, at 7:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1947 to 1/29 1947, and that I last saw him alive on 1/28 1947.

| Immediate cause of death | Duration |
|---|---|
| coronary occlusion | 9 hrs. |
| Due to arteriosclerosis | 4 yrs. |
| Due to arteriosclerotic heart | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Howard A. Kelly M. D.
Address: 2020 E. Chase Date signed: 1/30/47

VS 150

G48072

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G48072

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 347 Rosebank Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-12
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 347 Rosebank Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Varina Clark

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widowed |

6 (b) Name of husband or wife Henry S. Clark
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 7 | 25 | hr. min. |

9. Birthplace Baltimore Co., Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name John P. Clark
13. Birthplace St. Mary's Co., Md.

MOTHER
14. Maiden Name Jane Buckley
15. Birthplace Baltimore, Md.

16 (a) Informant Margaret J. Clark
(b) Address 347 Rosebank Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-31-47 (month) (day) (year)
(c) Cemetery or crematory St. Joseph's
Location Texas, Md.

18 (a) Funeral director John D. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place, Baltimore, Md.

JAN 30 1947 (Date rec'd by Registrar) (b) Huntington Hillsdale, Md. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 29 1947, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-f 1942 to 1-29 1947, and that I last saw her alive on 1-29 1947.

| Immediate cause of death | Duration |
|---|---|
| Arteriosclerosis & Hypertension | |
| C.V. disease | 5 years |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Nelson Carey M. D.
Address 1014 St. Paul St. Date signed 1-29-47

VS 150 JAN 2[illegible]

X

G18073 BCH BALTIMORE CITY HEALTH DEPARTMENT Registered No. G18073

CWK-107344 G67444 CERTIFICATE OF DEATH 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 Days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 720 N. Carey Street Z-17
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy Smith-Catherine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 6-1947

8. AGE: Years | Months | Days: 14 Days | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Walter Smith
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Catherine Smith
15. Birthplace: Washington-D. C.

16 (a) Informant: Records-Balto. City Hospitals
(b) Address: 4940 Eastern Avenue

17 (a) Cremation (cremation, ~~burial~~) (b) Date thereof 1-24-47 (month) (day) (year)
(c) ~~Cemetery~~ crematory: Baltimore City Hospitals
Location: 4940 Eastern Ave (Records)

18 (a) Funeral director
(b) Address

19 (a) JAN 30 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH January 20 1947, at 5:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 6 1947 to Jan. 20 1947, and that I last saw him alive on Jan. 20 1947.

| Immediate cause of death | Duration |
|---|---|
| Atelectasis | Life |
| Due to Prematurity | Life |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wilson E. Hughes M. D.
Address Balto City Hosp Date signed Jan 22 47

V S 190

X

G18074

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 161a

Registered No. G18074

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd Street
(c) Hospital or institution:
Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 2

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town White Hall
(If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Girl Lashorn

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | white | — |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 2 | hr. min. |

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER 12. Name George John Lashorn
13. Birthplace

MOTHER 14. Maiden Name Bessie Morrison
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Cared for by Hospital

18 (a) Funeral director
(b) Address

1947 JAN 30 1947 (Date rec'd by Registrar) (b) Huntingtown, Williamsport, Md

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24 1947, at 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22, 1947 to Jan 24 1947. and that I last saw h[illegible] alive on Jan. 24 1947.

Immediate cause of death

Neonatal Atelectasis Acute

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roberta J. Hurst M. D.
Address Union Memorial Hosp Date signed 1-28-47

VS 150

G48075

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G48075
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1520 Clarkson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Anne Arundel
(c) City or town: Severna Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box — 88 (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country —

3 (a) FULL NAME John D. Geisler

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widower |

6 (b) Name of husband or wife Marie Geisler (nee Hamm)
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 10, 1861

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 85 | 6 | 18 | hr. min. |

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business —

FATHER
12. Name George Geisler
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Augusta Lacer
15. Birthplace Germany

16 (a) Informant Mrs. Margaret Ellen Hetzer
(b) Address 1520 Clarkson St., Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 31, 1947 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Anne Arundel Co., Md.

18 (a) Funeral director G. Howard Evans
(b) Address 1400 E. Cleveland St., Baltimore, Md.

19 (a) (b) Registrar

JAN 30 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 28, 1947 at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/25 1947 to 1/28 1947 and that I last saw h— alive on 1/28 1947

Immediate cause of death: Senility - coma

| Duration |
|---|
| — |

Due to —

Due to —

Other Conditions None
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operations —
of autopsy —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

Signature Harry Geisler M. D.
Address 1716 Hanover St. Date signed 1/30/47

G48076

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48076 Registered No. 126

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: 4508 Luerssen Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town 4508 Luerssen Ave (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore Md (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles H Luerssen

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | W | Married |

6 (b) Name of husband or wife Caroline Luerrsen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 8 | 23 | hr. min. |

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Grocer & Builder
11. Industry or business

FATHER
12. Name Adolph C Luerssen
13. Birthplace Germany

MOTHER
14. Maiden Name Adelheit Helmken
15. Birthplace Germany

16 (a) Informant Mrs C H Luerssen
(b) Address 4508 Luerssen Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/47 (month) (day) (year)
(c) Cemetery or crematory Immanuel Lutheran
Location Grinden Ave Balto

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd Balto 6 Md

19 (a) Jan 30 1947 (Date received by registrar) (b) [signature]

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 29 47 19 9 a.m. 15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1947 to Jan 27 1947 and that I last saw him alive on Jan 29 1947

| | Duration |
|---|---|
| Immediate cause of death Coronary Occlusion | 2 hrs. |
| Due to Arterio Sclerosis | ? |
| Due to Chronic Cholecystitis | |
| Other Conditions Chronic Cholecystitis & Lithiasis | 5 years |

(Include pregnancy within 3 months of death)
Date of operation Lithiasis
Major findings of operation:
of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Lachman M.D.
Address 4930 Belair Rd Date signed Jan 30, 1947

VS 150

G48077

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48077 Registered No. 1242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts.
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Chase Md
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs Margaret Prescott

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | W |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/28/06

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 40 | 5 | 2 | hr. min. |

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Michael J Coyne
13. Birthplace Maryland

MOTHER 14. Maiden Name Margaret Knauff
15. Birthplace Balto Md

16 (a) Informant Mrs Walter Hare
(b) Address 5009 Alhambra Ave

17 (a) Burial (b) Date thereof 2/1/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Balto

18 (a) Funeral director Lackey Inc Funeral Home
(b) Address 7401 Belair Rd

19 (a) Temperington Williams M.D.
(Date received by registrar) Registrar

JAN 31 1947

VS 190

JAN 30 10

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1947 at 1:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28 1947 to Jan 30 1947 and that I last saw h.e.r alive on 19

Immediate cause of death: Cardiorespiratory failure

Due to: Chronic Cirrhosis

Due to:

Other Conditions Ascites

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: cirrhosis

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J B Wells M.D.

Address St Josephs Date signed 1/30/47

J.B. Wells, M.D.

G48078

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 194a

G48078 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 min
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2107 Dukeland St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles I Dailey Charles I. Dailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Leona E. Dailey
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) April 17, 1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | 9 | 13 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Self

FATHER
12. Name Charles J. Dailey
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine T. Johnston
15. Birthplace Washington, D. C.

16 (a) Informant Mrs. Leona E. Dailey
(b) Address 2107 Dukeland St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 1, 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director E. W. Thomsen
(b) Address 4510 Liberty Heights Ave.

30 1947 (Date rec'd by registrar) (b) Registrar

VS 151

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 1/30 1947 at 12 15 A.M.

**21.** I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Sabatini M.D.
Medical Examiner.
Date signed 1/31/47

G48079

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48079 Registered No.

508573

1579

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va (b) County
(c) City or town Fairmount (If outside city or town limits, write RURAL and give town)
(d) Street No. Country Club Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Kline

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 18-47

8. AGE: Years | Months | Days: 11 | If less than one day: hr. min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Charles Kline

13. Birthplace Kentucky

MOTHER 14. Maiden Name Virginia Aberne

15. Birthplace Illinois

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN 30-47 (month) (day) (year)

(c) Cemetery or crematory FAIRMOUNT

Location W-K A

18 (a) Funeral director John D Mitchell

(b) Address 600 Eastern Ave.

19 (a) Date received by Registrar JAN 30 1947 (b) Registrar Wilmer Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1947, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1947 to Jan 30 1947, and that I last saw him alive on Jan 20 1947.

| Immediate cause of death | Duration |
|---|---|
| Aspiration Pneumonia | 6 da. |
| Due to Regurgitation feeding | |
| Due to Operation - esophagectomy for esophagus and to end + closure | |
| Other Conditions Carcinoma esophagus Fistula | |

(Include pregnancy within 3 months of death)

Date of operation 1-24-47

Major findings of operation: Atresia esophagus + tracheoesophageal fistula

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D J Jaggis

Address Johns Hopkins Hospital Date signed 1-30-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43080

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

G43080 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd St & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 153 ds
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 909 Greenleigh Rd (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Elizabeth Rolker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Wh | 6 (a) Single, married, widowed, or divorced. Wid

6 (b) Name of husband or wife John G. Rolker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1870

8. AGE: Years 76 | Months 6 | Days 14/13 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Flamm
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Md

16 (a) Informant Irving Rolker
(b) Address 909 Greenleigh Rd, Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) JAN 31 1947 Huntington for Williams, M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 29 1947 at 9:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/29 1946 to 1/29 1947, and that I last saw h. alive on 1/29 1947

Immediate cause of death: Carcinomatosis — Duration: 1 year

Due to Cancer of breast, left — 3 years

Due to

Other Conditions ASHD — Years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Williams
Address Union Memorial Hosp Date signed 1/29/47

G48081

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 163#

G48081 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 221 S. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary V. Steyer (STEYER)

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-16-6699

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife Wilfred J. Steyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 11th 1916

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 30 | 3 | 1819 | hr. min. |

9. Birthplace W. Va.
(Town, county, and state)
10. Usual Occupation Chanteuse
11. Industry or business Sun Cab Co

FATHER
12. Name (Unknown) Goff
13. Birthplace W. Va.

MOTHER
14. Maiden Name Marie (Unknown)
15. Birthplace " "

16 (a) Informant Wilfred J. Steyer
(b) Address 221 S. Broadway

17 (a) Burial (b) Date thereof 2/1/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Maryland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) (b) William Cook
(Date rec'd by registrar)

JAN 31 1947

VS 181

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/30 19 47 at 1 25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxia due to
Illuminating gas
Due to
Other Conditions Despondency
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/30/47 at about 12 P.M.
(b) Where did injury occur? 221 S. Broadway
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Inhalation of gas from open jet burner

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 1/30/47

G48082 BC# G68663

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

Registered No. G48082

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1422
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days.

**2. USUAL RESIDENCE OF DEACTIVATED:**
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town, write RURAL and give town)
(d) Street No. 14 22 Mountmore Court
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy Blackwell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Negro | Single |

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| — | — | 9 | hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Charles E. Blackwell
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Priscilla M. Wallace
15. Birthplace Prince George Co., Maryland

16 (a) Informant Charles E. Blackwell
(b) Address 1422 Mountmore Court

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

JAN 31 1947
(Date rec'd by registrar)

Commissioner of Health

Huntington Williams M.D.

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan. 25 1947 at 1:50 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan. 16 1947 to Jan. 25 1947 and that I last saw him alive on Jan 24 1947.

| Immediate cause of death | Duration |
|---|---|
| Anoxia | |
| Due to Prematurity | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature L. M. Williams M.D.
Address University Hospital Date signed Jan 25, 47 M. D.

G18083 BCH G18083

BALTIMORE CITY HEALTH DEPARTMENT

507947. G67602 CERTIFICATE OF DEATH 1579

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 589 Wolman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Dora Ratt.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Black | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-12-47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 15 | hr. min. |

9. Birthplace md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name 2 2.
13. Birthplace 2

MOTHER
14. Maiden Name Dora Ratt.
15. Birthplace S.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 28 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 31 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 190

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH Jan. 27 1947 at 5.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 12 1947 to Jan. 27 1947 and that I last saw h[illegible] alive on Jan. 27 1947.

| Immediate cause of death | Duration |
|---|---|
| MARASMUS | 10 days |
| Due to Intestinal obstruction | 10 days |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Distended small large intestine
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D H Jaggar
Address Johns Hopkin Hospital Date signed 1-28-47

X

G48081

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. G48084

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5605 Wayne Ave.
(c) Hospital or institution: 58
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5605 Wayne Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Carrie Mildred Tansill

3 (b) If veteran, name war ----------
3 (c) Social Security Account No. ----------

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife John Leland Tansill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12, 1892

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 | 1 | 17 | hr. min. |

9. Birthplace Brook lyn New York (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name William L. Emerick
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Anna B. Hause
15. Birthplace Maryland

16 (a) Informant Robert Tansill
(b) Address 5605 Wayne Ave.

17 (a) Burial (b) Date thereof 2-1-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Fairview Cemetery
Location Westfield New Jersey

18 (a) Funeral director Ellsworth Kincaid
(b) Address 3911 Liberty Heights Ave.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.
JAN 31 1947

VS 10

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 29 1947, at 7 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 8 1947, to Jan 29 1947, and that I last saw her alive on Jan 27 1947.

| Immediate cause of death | Duration |
|---|---|
| Subarachnoid hemorrhage | 5 days |
| Due to Arterio-sclerosis | 6 yrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Homer L. Todd M. D.
Address 2108 St Paul St Date signed 1/30/47

G48085

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G48085 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15 N. Pearl Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie DEATHS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 70 Months Days If less than one day hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Samuel Death
13. Birthplace —

MOTHER 14. Maiden Name Annie Berry
15. Birthplace —

16 (a) Informant Welfare Record
(b) Address Balto City

17 (a) Burial (b) Date thereof 1-31-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Johns
Location Ellicott City Md

18 (a) Funeral director Frank H Seitz
(b) Address 814 N 36th

19 (a) JAN 31 1947
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21, 1947 at 11.50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic heart disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 1/22/47

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48086 BCH BALTIMORE CITY HEALTH DEPARTMENT G48086
G48086 G68030 CERTIFICATE OF DEATH 157E Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Lafayette and John Sts.
(c) Hospital or institution Women's Hospital 13

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 da
(e) Length of stay in Baltimore (yrs., mos., or days) 13 da

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1342 West North Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Cullings - Carol Lynn

3 (b) If veteran, name war | (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 17, 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 0 | 0 | 13 | hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Rae Van Lear Cullings
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna Matilda Lucas
15. Birthplace Baltimore, Md.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial, (b) Date thereof Jan. 31-1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Cemetery or crematory Meadow Ridge Mem. Park
Location Howard Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3621 Falls Road

19 (a) (b)
(Date rec'd by registrar) Registrar

VS Jan 31 1947 Huntington Williams, MD

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 30 1947 at 6 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1947 to Jan 30 1947 and that I last saw her alive on Jan 30 1947

| Immediate cause of death | Duration |
|---|---|
| Cardio-Respiratory Failure | |
| Due to Congenital Atelectasis, Bilateral | 13 da. |
| Due to | |
| Other Conditions Congenital Heart Disease (Patent ductus Arteriosus) | 13 da. |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation Ductus Arteriosus

of autopsy Cong. Atelectasis; Patent d

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James H. McCook M. D.
Address Women's Hospital Date signed 1/30/47

G18087

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83B

Registered No. G18087

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1642 E Balto. St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town 1642 E. Balto. St
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marcus Ebenstien

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Betty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years 85 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Poland

MOTHER
14. Maiden Name Not Known
15. Birthplace Poland

16 (a) Informant Samuel Volkin
(b) Address 1642 E. Balto. St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-31-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phil Rd-Hamilton Ave

18 (a) Funeral director Volck Lewis Inc
(b) Address 1439 E. Balto St

19 (a) (Date received by registrar) JAN 31 1947 (b) Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-31-47 19 ; at 5:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-18 1938 to 1-30 1947. and that I last saw him alive on 1-30-1947

Immediate cause of death Cerebral Thrombosis. — Duration 5 days

Due to

Due to

Other Conditions Umbilical and Bi-Lateral Inguinal Hernias.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Levin
Address 14 S Broadway Date signed 1/31/47 M. D.

G48088

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 107

Registered No. G48088

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Aged Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Greenspring Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** DAVID FEINBERG

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife Bessie.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Aged Home
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-31-47 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Old Forney Hill Road

18 (a) Funeral director Jacob Levin Sons
(b) Address 1439 E. Baltimore St

19 (a) 1-31-47 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 31 1947, at 6.30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17 1943, to 1-31 1947, and that I last saw h.. alive on 1-31 1947.

| Immediate cause of death | Duration |
|---|---|
| Broncho-pneumonia | |
| Due to Bronchiectasis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Edmund Levin, M. D.
Address Owings Mills Date signed 1/31/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48089 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G48089

# CERTIFICATE OF DEATH ✓ 937

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1301 Park Ave.
(c) Hospital or institution: Thirteen Hundred & One Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Va. (b) County Lancaster
(c) City or town Irvington (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** SARAH ELIZABETH JAMES

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | no |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | white | widow |

6 (b) Name of husband or wife Alonzo James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1863

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 8 | 0 | hr. min. |

9. Birthplace Lancaster Co., Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edwin George
13. Birthplace Lancaster Co., Va.

MOTHER
14. Maiden Name Lucy Leland
15. Birthplace Lancaster Co., Va.

16 (a) Informant Mrs. Osborne T. Biddle
(b) Address Garden Apts., Balto., Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/1/47 (month) (day) (year)
(c) Cemetery or crematory Whitestone Cem.
Location Whitestone, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) JAN 31 1947 (b) Registrar Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30, 1947, at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 23 19 47 to Jan. 30 19 47 and that I last saw h alive on Jan. 30 19 47

Immediate cause of death: Pulmonary Edema — Duration 3 days

Due to: General Arterio Sclerosis — Duration 2 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thom E. Wilson M. D.
Address 3 W. Biddle St. Date signed 1-30-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48090

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G48090

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2100 Rosedale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2100 Rosedale S t.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** LOUISE W. HENDERSON

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | 220-12-7698 |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 0 | 26 | hr. min. |

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Clerical Work
11. Industry or business Hutzler Bros. Co.

FATHER
12. Name Daniel M. Henderson
13. Birthplace Glasgow, Scotland

MOTHER
14. Maiden Name Alice Ashcroft
15. Birthplace Scotland

16 (a) Informant Mr. Walter S. Henderson, brother
(b) Address 2231 Poplar Grove St.

17 (a) Burial (b) Date thereof 2/1/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address 1841 Bolton St., Md.

19 (a) (Date rec'd by registrar) JAN 31 1947 (b) Huntington Williams, M.D. (Registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 29, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 28 1947 to Jan 29 1947, and that I last saw h[illegible] alive on Jan 28 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary Occlusion | 24 hrs |
| Due to Coronary Thrombosis | 24 hrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Daniel Robinson M. D.
Address 2435 Guilford Ave Date signed Jan 29 1947
Howard J. Mackert, M. D.

G18091

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G18091

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3507 Holmes Ave
(c) Hospital or institution:

13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3507 Holmes Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Jacob Fishel

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widower |

6 (b) Name of husband or wife Late Regina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | | | hr. min. |

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name Unkown
13. Birthplace Germany

MOTHER
14. Maiden Name Unkown
15. Birthplace Germany

16 (a) Informant Mrs Minnie Rudo.
(b) Address 3507 Holmes Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 31, 1 (month) (day) (year)
(c) Cemetery or crematory Har Zion Cong Cem
Location Herring Run

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 JAN 31 1947

**MEDICAL CERTIFICATION** 6.30

20. DATE OF DEATH January 31 1947, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1936, to Jan 31, 1947.
and that I last saw h[illegible] alive on Jan. 30, 1947.

Immediate cause of death Coronary thrombosis — Duration 1 day
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney D. Levy M. D.
Address 23 W Eutaw Pl Date signed 1/31/47

X

G48092

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

131a

Registered No. G48092

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1532 Druid Hill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1532 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William A Hawkins Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1875

8. AGE: Years 72 | Months 3 | Days 7 | If less than one day: hr. min.

9. Birthplace Charlottesville, Va (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Arthur Bernard Hawkins
13. Birthplace Albermarle Co. Va

MOTHER
14. Maiden Name Edith Southall
15. Birthplace Albermarle Co. Va.

16 (a) Informant Mrs. Margaret E. Hawkins
(b) Address 1532 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 31, 1947 (month) (day) (year)
(c) Cemetery or crematory Greenmount Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Chas. H. Holland
(b) Address 1631 Druid Hill Ave

19 (a) (Date received by Registrar) JAN 31 1947 (b) Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1947, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 1947 to 1-28 1947, and that I last saw h[e] alive on 1-28 1947

| | Duration |
|---|---|
| Immediate cause of death: Cerebral Thrombosis | 1 Day |
| Due to: Cardio-Renal | |
| Due to: V.D. Endocarditis | |
| Other Conditions: Hemiplegia (Left) | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature [signature]
Address 1207 N Carlton Date signed 1/30/47 M. D.

G48093

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 457

G48093 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 309 S. Payson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 S. Payson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Frank Bastion

3 (b) If veteran, name war #1

3 (c) Social Security Account No.

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22, 1886

8. AGE: Years 60. Months 11 Days 8 If less than one day hr. min.

9. Birthplace Toledo, Ohio (Town, county, and state)

10. Usual Occupation Plumbers Helper

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Ohio

MOTHER 14. Maiden Name Unknown

15. Birthplace Ohio

16 (a) Informant Mrs. Florence L. Blair

(b) Address 309 So. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/47 (month) (day) (year)

(c) Cemetery or crematory Baltimore Memorial Park

Location 5501 Frederick Road

18 (a) Funeral director John F. Cowan Son

(b) Address 401-403 Dolphin St.

19 (a) (Date rec'd by registrar) JAN 31 1947 (b) Huntington Williams M.D.

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan 30, 1947 at 3:45 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 10/1 1946 to 1/30 1947 and that I last saw h[illegible] alive on 1/30 1947

Immediate cause of death Carcinoma of jaw left

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 3 mos

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller MD M. D.
Address 20 30 Wilkens Date signed avi X 1/31/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

C48094 ✓ 181 Registered No. C48094

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 19 N. Carey St.
(c) Hospital or institution: 18

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** EDWARD McGINITY ✓

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| ✓ | ✓ |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | white | single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | | | hr. min. |

9. Birthplace Cockeysville, Baltimore Co., Md
(Town, county, and state)

10. Usual Occupation Tobacco Stemmer
11. Industry or business Tobacco Factory

FATHER
12. Name Thomas McGinity
13. Birthplace Ohio

MOTHER
14. Maiden Name Unknown
15. Birthplace Ohio

16 (a) Informant Mr. Corbett 6 Bowersox
(b) Address 113 S. Caroline Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4230 Old York Road

18 (a) Funeral director John J. Corcoran & Son
(b) Address 1911 E. Fayette Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

JAN 31 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30, 1947, at 11:41 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia;
acute Dilatation of the heart;
Coronary disease; Generalized
Due to arteriosclerosis; Splenic
tumor; Inspected hand at the
first joint of the little
finger; Anemia.
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 1-1-47 (E) at ? M.
(b) Where did injury occur? 19 N. Carey St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? yes
(d) Means of injury Burned hand while cleaning can

23. Signature Howard J. Mennemeyer M.D.
Medical Examiner.
Date signed 1-30-47

X

G18095

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 194a

Registered No. G18095

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3922 Norfolk Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3922 Norfolk Ave.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** JACOB ROSENBAUM.

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Carrie R. Rosenbaum
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1885.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 5 | 25 | hr. min. |

9. Birthplace Germany. (Town, county, and state)
10. Usual Occupation Retired.
11. Industry or business

FATHER
12. Name Moses Rosenbaum,
13. Birthplace Germany.

MOTHER
14. Maiden Name Regina Gutman,
15. Birthplace Germany.

16 (a) Informant Mrs. Carrie R. Rosenbaum,
(b) Address 3922 Norfolk Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1.31.47. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director David Lomatkin & Son
(b) Address 1902 Eutaw Place.

19 (a) (Signature of local registrar) (b) Registered JAN 31 1947

VS 180

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 30th. 1947, 4.50PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/23 19 47, to 1/30 19 47, and that I last saw h[illegible] alive on 1/30 1947.

Immediate cause of death — Duration
Acute Coronary Thrombosis — 2 days
Due to
Due to
Coronary Sclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2904 Reisterstown Rd. Date signed

X

G48096

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

✓171a

Registered No. G48096

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 8 S. Washington St.
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 8 S. Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John GRUDZIECKI

3 (b) If veteran, name war

3 (c) Social Security Account No. none

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | - | 27 | hr. min. |

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business For self

FATHER
12. Name Kapser Grudziecki
13. Birthplace Poland

MOTHER
14. Maiden Name Modrzijewski
15. Birthplace Poland

16 (a) Informant Mary Grudziecki
(b) Address 8 S. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 1 '47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Ozarzuski
(b) Address 1930 Eastern Ave.

19 (a) Registered Jan 31 1947
Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan. 28, 1947, at 11.40 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary embolus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 2/1
(a) Date of injury 11/15/46 at 6 P. M.
(b) Where did injury occur? Baltimore & Wolfe Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Person struck by a street car.

23. Signature George L. Merrill M.D.
Medical Examiner.

Date signed 1/30/47

X

G48097

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

G48097 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1318 Patapsco Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1318 Patapsco Av (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** William F. W. Parks

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widower |

6 (b) Name of husband or wife Margaret L. Parks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27, 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 4 | 3 | hr. min. |

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Retired Postal Employee
11. Industry or business U. S.

| | |
|---|---|
| FATHER — 12. Name | John W. Parks |
| FATHER — 13. Birthplace | Balto Md |
| MOTHER — 14. Maiden Name | Elizabeth Mongarity |
| MOTHER — 15. Birthplace | Md |

16 (a) Informant Mrs. Estelle F. Parks wife
(b) Address 1004 W. 15th Ave. Brooklyn Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 3, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto Md

18 (a) Funeral director A. Boyd Evans
(b) Address 1400 E. Baltimore St.

19 (a) (Date rec'd by registrar) JAN 31 1947 Registrar

VS

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 30 1947, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/25 1947 to 1/30 1947 and that I last saw h[illegible] alive on Jan 30 1947

Immediate cause of death: Cerebral Hemorrhage — Duration: 4 days
Due to:
Due to arteriosclerosis
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Mills M. D.
Address 225 S Clinton St Date signed

1/31/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18098

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G18098 Registered No. 438

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1902 E. 31st Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1902 E. 31st St. (If rural give location)
(e) Citizen of foreign country? ---- (Yes or No)
If yes, name country ----

3 (a) FULL NAME MARGARET CECILIA WELSH

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Martin J Welsh, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23. 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 3 | 5 | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name James Kehoe
13. Birthplace Ireland

MOTHER
14. Maiden Name Cecilia Kavanaugh
15. Birthplace Ireland

16 (a) Informant Mr Martin J. Welsh, Sr.
(b) Address 1902 E. 31st Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. H. Mears and Son
(b) Address 805 N. Calvert St.

19 (Date rec'd by registrar) JAN 31 1947 Huntington Williams, Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 28 1947 at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 9 1943 to JAN 28 1947 and that I last saw h[illegible] alive on Jan. 28 1947

Immediate cause of death Cerebral Thrombosis (Left) — Duration 18 hours
Due to Thrombophlebitis
Due to Arteriosclerosis Hypertension
Other Conditions Hypertrophic Arthritis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. V. Harbold M. D.
Address 4706 Harford Road Date signed 1/31/47

VS 150

X

G48099

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 51B

Registered No. G48099

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address North Broadway.
(c) Hospital or institution: Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore 24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr James Simmons

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Mrs Emma Simmons
6 (c) If alive, give 69 years

7. Birth date of deceased (mo., day, yr.) Feb 2, 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78. | 11 | 24 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Road Supt
11. Industry or business Road Supt.

FATHER
12. Name Michael Simmons
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Hayes
15. Birthplace Ireland

16 (a) Informant Mr Abby Simmons (Son)
(b) Address 2202 Eastern Ave.

17 (a) Burial (b) Date thereof 1/31/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (b) Registrar
(Date rec'd by registrar)

VS 150 JAN 31 1947 Huntington Williamsport, Md.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 29 1947, at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 11 1947, to Jan 29 1947, and that I last saw him alive on Jan 29, 1947.

Immediate cause of death
Bronchopneumonia Left
Antecedent cause, if any - (Cancer embryonic)
Due to Adenocarcinoma of prostate
Antecedent cause, if any - (Cancer embryonic)
Due to Arteriosclerotic Heart disease.

| Duration |
|---|
| 20 days |
| 2 days |
| 5 yrs. |
| 15 yrs. |
| 15 yrs. |

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Bachanek M. D.
Address Church Home & Hosp Date signed Jan 29, 47

G48100

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1314

G48100 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1817 E. 30th Street
(c) Hospital or institution: grb
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 E. 30th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** CATHERINE NELSON

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 8 | 26 | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Nicholas Nelson
13. Birthplace Norway

MOTHER
14. Maiden Name Dorothea Stroh
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs John F. Rahn
(b) Address 1817 E. 30th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) JAN 31 1947 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 19 47 6 45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1947 to June 30 1947, and that I last saw her alive on June 29 1947

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia | 3 d. |
| Due to Cerebral Hemorrhage | 7 d. |
| Due to Arterio Sclerosis | 4 yrs |
| Hypertension | 25 yrs |
| Other Conditions Chr Interstitial Nephritis | 28 d. |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J F A Strouss M. D.
Address 2876 Harford Rd Date signed 1-30-47

830

G48101

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G48101

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 127 S. Linwood
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs 5 mos

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 127 S. Linwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Morgan Langley

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jane Langley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 30, 1878

8. AGE: Years 68 | Months 5 | Days - | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Engineer Retired

11. Industry or business Baltimore City Jail

FATHER
12. Name James Polk Langley
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Morgan
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Jane Langley
(b) Address 127 S. Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 3, 47 (month) (day) (year)

(c) Cemetery or crematory Parkwood Mem.
Location Harford Rd.

18 (a) Funeral director Frank V. Pipitone
(b) Address 2818 E. Baltimore St.

19 JAN 31 1947 (b) Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Jan. 30 1947, at 7:6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946, to Jan 1947, and that I last saw him alive on Jan 30 1947.

Immediate cause of death Pulmonary Edema

Due to Arteriosclerotic Heart Dis

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

| Duration |
|---|
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles G. MacMunn M. D.
Address 2911 E. Balto St Date signed Jan 30, 1947

X

MARY

G48102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G48102

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1104 E. Fort Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 E. Fort Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary L. Thompson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | M. |

6 (b) Name of husband or wife Foster.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb 13, 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 9 | 17 | hr. min. |

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business —

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Family
(b) Address 1104 E Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-3-47 (month) (day) (year)
(c) Cemetery or crematory Cley Haven
Location Edenburgh

18 (a) Funeral director James L. McCully
(b) Address 130 E. Fort Ave.

19 JAN 31 1947 Huntington Williams M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-30-47 19 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15-47 19 to 1-30-47 19, and that I last saw h[illegible] alive on 1-30-47 19

| | Duration |
|---|---|
| Immediate cause of death [redacted] Coronary Occlusion | |
| Due to Arteriosclerosis. | 5 yrs + |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. E. Zaugg M.D.
Address 642 Wash. Blvd Date signed 1-21-47 M. D.

X

G-8103

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 56a

G-8103 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 500 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Florence Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-23-91

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55+ | 7 | 4 | hr. min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Sam Jones
13. Birthplace Md

MOTHER
14. Maiden Name Mary ?
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Gate, Md

18 (a) Funeral director Elroy J. Wilson
(b) Address 10001 Brantley Ave

JAN 31 1947 Registrar of Vital Statistics

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 27 1947 at 5:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24 1947 to Jan 27 1947 and that I last saw her alive on Jan 27 1947

| Immediate cause of death | Duration |
|---|---|
| Hemorrhage into stomach | 10 min |
| Due to Ovarian cyst | ? 1 yr |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Z. Mason M. D.
Address Johns Hopkins Hosp Date signed 27 Jan 47

VS 150

C48104

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. C48104

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 822 N. Carrollton Ave. 16
(c) Hospital or institution:
N. M. Carroll Home for the Aged
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 N. Carrollton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** LOUISE McLAIN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | Widow |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1869

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 7 | - | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name John H. Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Lewis
15. Birthplace Md.

16 (a) Informant Miss Rosa Stewart
(b) Address 822 N. Carrollton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 JAN 31 1947 (b) Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 30 1947, at 2:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from NOV. 30, 1946 to JAN. 27 1947 and that I last saw HER alive on JAN 27 1947.

| Immediate cause of death | Duration |
|---|---|
| ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE | 1 YR |
| Due to GENERALIZED ARTERIOSCLEROSIS | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation:
of autopsy: NONE

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Thomas W. Harris, Jr. M. D.
Address 1824 W. Franklin St. Date signed 1-30-47

VS 180

G48105

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 B

Registered No. G48105

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2330 McCulloh St
(c) Hospital or institution:
13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2330 McCulloh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ARTHUR E. BRISCOE

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Colored | Married |

6 (b) Name of husband or wife Lavenia Briscoe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 5 | 28 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business

FATHER
12. Name Abraham Briscoe
13. Birthplace St. Mary Co., Md.

MOTHER
14. Maiden Name Caroline Scott
15. Birthplace Md.

16 (a) Informant Mrs. Lavenia H. Briscoe
(b) Address 2330 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

JAN 31 1947 (Date rec'd by Registrar) (b) [signature] (Registrar) Baltimore, Md.

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH January 30, 1947, at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1946 to Jan 29 1947 and that I last saw h[illegible] alive on Jan 29 1947

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of Stomach | 9 |
| Due to | |
| Due to | |
| Other Conditions Exhaustion | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 1423 Druid Hill Av Date signed Jan 31-47

VS 150

G18106

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46E

Registered No. G18106

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1500 Lakeside Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1500 Lakeside Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Emma Frances Austin

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: John Austin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1863

8. AGE: Years 83 | Months 10 | Days 8 | If less than one day hr. min.

9. Birthplace: Eastbourne, England
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name George M. Parker
13. Birthplace England

MOTHER
14. Maiden Name Emma E. Turner
15. Birthplace England

16 (a) Informant Herbert J. Austin
(b) Address 1500 Lakeside Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) Jan 31 1947 [illegible]

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 30 1947, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1946, to Jan 30 1947, and that I last saw her alive on Jan 24 1947

Immediate cause of death: Cancer of Cervix — | Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry D. McCarty M. D.
Address 37 W. Preston St. Date signed

VS 150

G48107 State Collection 9-68972

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 161a

Registered No. G48107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2917 Edison Hgwy (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Buckleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 27 1947

8. AGE: Years | Months | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Buckleman
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Laura Rice
15. Birthplace Virginia

16 (a) Informant John Buckleman
(b) Address 2917 Edison Hgwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 1, 47 (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location Baltimore Md

18 (a) Funeral director Maynard E. Covington
(b) Address 21 W. 25th St.

19 JAN 31 1947 (b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1947 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 29 1947 to Jan 30 1947 and that I last saw her alive on Jan 30 1947

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions Prematurity
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jerome J. Michael M. D.
Address Sinai Hosp Date signed Jan 30 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G48108 BALTIMORE CITY HEALTH DEPARTMENT G48108

# CERTIFICATE OF DEATH 61

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 49 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3414 Chestnut Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Sadie Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed or divorced: Widowed

6 (b) Name of husband or wife: Alfred Moore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug 14 1878

8. AGE: Years: 68 Months: 5 Days: 15 If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Casper Faulgenhem
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Marie Finn
15. Birthplace: Ireland

16 (a) Informant: Patient
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd.

18 (a) Funeral director: Kenneth V. Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) (Date rec'd by registrar) (b) (Registrar)

VS Form JAN 31 1947 Washington, D.C.

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1947 at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 23 1947 to Jan 29 1947 and that I last saw her alive on Jan 29 1947

Immediate cause of death: Cardiac - respiratory failure — Duration:
Due to: Arteriosclerotic Heart Disease
Due to: Arteriosclerotic Renal Disease
Other Conditions: Diabetes Mellitus, Hydrothorax - bilateral

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Clarence E. McWilliams Jr. M.D.
Address: Mercy Hospital Date signed 1-29-47

937

G48109

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

G48109 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 850 W 36th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 850 W 36th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary E. Williams.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | white | Single |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 23, 1869

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 3 | 6 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation none.
11. Industry or business

FATHER
12. Name Joseph T. Williams.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Sophia Smith
15. Birthplace Maryland.

16 (a) Informant Mrs. Ida Hood.
(b) Address 905 W 37th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 1/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Edmond P. Donovan
(b) Address 3615 Eastern Ave

19 (a) (Date received) JAN 31 1947 Hunting for Williams

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 29, 1947, at 9 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 1947 to Jan 29 1947 and that I last saw h alive on Jan 29 1947.

Immediate cause of death Pneumonia

Duration: 10 days

Due to Chronic Cardio Renal disease

Duration: 10 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leon Dubelier, M.D. Address 850 W 36th St. Date signed 1/30/47

VS 150

G48110

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 51B

Registered No. G48110

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore 31,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 South Ann Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Helinski

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-0367

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of ~~husband~~ wife Julianna
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Dec, 16-1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 1 | 14 | hr. min. |

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Peter Helinski
13. Birthplace Poland

MOTHER
14. Maiden Name Victoria ?
15. Birthplace Poland

16 (a) Informant Mrs. Julianna Helinski
(b) Address 618 South Ann Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-3-47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

19 (a) [illegible] (b) [illegible] Williamsport, Md.
Jan 31 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 30 1947 at 12:40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 1946 to Jan. 30 1947 and that I last saw h~~im~~ alive on Jan. 30 1947

Immediate cause of death Cardiac failure and pulmonary edema — Duration

Due to Toxemia

Due to Septicemia

Other Conditions Carcinoma of prostate

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Lerman M. D.
Address Sinai Hospital Date signed 1-30-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48111

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G48111 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 17 E. Randall St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 17 E. Randall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John M. Striegel
3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed or divorced. |
|---|---|---|
| M | W. | Married |

6 (b) Name of husband or wife Mary Striegel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13. 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 4 | 16 | hr. min. |

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Conductor
11. Industry or business B&O. R.R.

FATHER
12. Name Martin Striegel
13. Birthplace Germany

MOTHER
14. Maiden Name Carolina Kastner
15. Birthplace Germany

16 (a) Informant Mrs Mary Striegel
(b) Address 17 E. Randall St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-1947 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location G. A. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) JAN 31 1947 Registrar
VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 29 1947, at 5:07 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1947 to Jan 29 1947 and that I last saw h. alive on Jan 29 1947

Immediate cause of death Coronary Thrombosis

Due to

Due to

Other Conditions Arteriosclerosis - Hypertension - Uremia

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

| Duration |
|---|
| |
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature John C. Schwenk M. D.
Address 1337 S. Charles St Date signed 1/31/1947

G48112

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13B

Registered No. G48112

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 824½ W. Lombard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4"
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 729 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles M. Howard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 3-1880

8. AGE: Years 66 | Months 5 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Howard
13. Birthplace —

MOTHER 14. Maiden Name —
15. Birthplace —

16 (a) Informant Clara A. Piper
(b) Address 824½ W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-1947 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Flepper & Fleming
(b) Address 1496 Light St.

19 (a) JAN 2 1 1947 (Date received by Registrar) (b) 1947 Registrar

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 1/29/ 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to Jan 29 1947, and that I last saw h[illegible] alive on Dec 1946

| | Duration |
|---|---|
| Immediate cause of death Myocardial Failure | 1 day |
| Due to Pulmonary Tuberculosis | 1 yr. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. Hightstein M. D.
Address 888 W. Lombard St Date signed 1-30-47

X

G48113 BCH G60660

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 31F

G48113 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital VD
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 Hollins St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Jasper Moore

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Unpost

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 25 1926

8. AGE: Years | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jasper R. Moore
13. Birthplace Bishop Head md

MOTHER 14. Maiden Name Bessie L. Hales
15. Birthplace Miza Miss.

16 (a) Informant Jasper R. Moore
(b) Address 713 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-47 (month) (day) (year)

(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director Frederick A. Cole
(b) Address 1700 N. Loudon Ave

19 (a) JAN 31 1947 (Date received by registrar) Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 30 1947, at 4:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1947, to Jan 30 1947, and that I last saw h.m. alive on Jan 30 1947.

| Immediate cause of death | Duration |
|---|---|
| Congenital Syphilis | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles R. Holmes M. D.
Address Univ. Hospital Date signed 2/1/47

X

G48111

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 124B

G48114 ✓ Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 804 Argonne Drive
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Bity - Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 804 Argonne Drive
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

**3 (a) FULL NAME** Rosario Marino

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | widowed |

6 (b) Name of husband or wife Concetta Marino
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 10 -1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 2 | 21 | hr. min. |

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Leather.

FATHER
12. Name Charles Marino
13. Birthplace Italy

MOTHER
14. Maiden Name Rose Culotta
15. Birthplace Italy

16 (a) Informant Rose M. Virgilio
(b) Address 1360 Southwestern Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 31 1947 (Date received by registrar) (b) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 31 1947, at 12:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1947 to Jan 31 1947, and that I last saw him alive on Jan 31 1947.

| Immediate cause of death | Duration |
|---|---|
| Toxemia | 3 da. |
| Due to Cirrhosis of Liver | 3 mos. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank D Virgilio M.D.
Address 1011 N Charles St Date signed 1/31/47

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48115

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1318

G48115 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 Elmwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baltimore C Thornton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| male | White | Married |

6 (b) Name of husband or wife Collette Moosberg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1899

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 47 | 6 | 8 | hr. min. |

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation Mechanic
11. Industry or business Railway Express

FATHER 12. Name Wm. P. Thornton
13. Birthplace Md

MOTHER 14. Maiden Name Mary Fuller
15. Birthplace Md

16 (a) Informant Mrs Collette Thornton
(b) Address 1210 Elmwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2.3.47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3501 Frederick Ave

18 (a) Funeral director Harry A. Wilkes
(b) Address 1401 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

vs 1a JAN 31 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-30 1947 at 2:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17 1947 to 1-30 1947 and that I last saw h/ alive on 1-30 1947

Immediate cause of death Respiratory Failure
Due to Uremia
Due to Chronic Glomerular Nephritis
Other Conditions
(Include pregnancy within 3 months of death)

| Duration |
|---|
| |
| |
| |
| |
| |
| |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lindsay W. Hollyday M. D.
Address St Agnes Hosp Date signed 1-30-47

G48116

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131B

Registered No. G48116

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3621 Edmondson Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3621 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Warren Stone

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-07-3227

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M. | W. | Married |

6 (b) Name of husband or wife Annie M. Stone (nee Meek) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 11 | 23 | hr. min. |

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Retired

FATHER
12. Name Walter Stone
13. Birthplace N.Y.

MOTHER
14. Maiden Name —
15. Birthplace Md

16 (a) Informant Mrs. Annie M. Stone - wife
(b) Address 3621 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 1 '47 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Kuhlke
(b) Address 4101 Edmondson Ave

19 (a) (Date received) (b) Registrar

JAN 31 1947

V S 130

Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/29/47 19 , at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/27/47 19 to 1/29/47 19 , and that I last saw h alive on 1/29/47 19

| Immediate cause of death | Duration |
|---|---|
| Uraemia | 3 days |
| Due to Nephritis | duration |
| Due to Enlarged Prostate | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Walter F. Dorsey M.D.
Address Hospital Date signed 1/30/47

Death Certificate No. 61272
G48117

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

170c

Registered No. G13117

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore City Hospital (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** PATRICK B HORAN

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 3 2 | 5 2 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Michael Horan
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah Corlin
15. Birthplace Ireland

16 (a) Informant Mrs Michael Horan
(b) Address 307 S. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 3 1947 (month) (day) (year)
(c) Cemetery or crematory St. Joseph
Location Towson, Md

18 (a) Funeral director Harry N Withe
(b) Address 714 Edmondson Ave

19 (a) JAN 31 1947 (Date rec'd by registrar) Washington Williams, M.D.

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 19 47, at 8:24 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Shock from fractures of pelvis and left leg.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-30-47 at 6:15 19[illegible] P.M.
(b) Where did injury occur? Lombard & Calhoun
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Pedestrian struck by auto

23. Signature George A. Merrill M.D. Medical Examiner.
Date signed 1/31/47

correct age is especially important. Physicians: please write the

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1318

G48118 ✓ G48118

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Oliver & Caroline Sts
(c) Hospital or institution:
St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 127 N. Clinton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mr George A. Kramer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary A. Kramer

6 (c) If widow, give age years

7. Birth date of deceased (mo., day, yr.) June 5 - 1911

8. AGE: Years 35 | Months 7 6 | Days 25 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Andrew F. Kramer

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Margaret Lauterbach

15. Birthplace Balto. Md.

16 (a) Informant Mary A. Kramer

(b) Address 1318 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/47 (month) (day) (year)

(c) Cemetery or crematory Pikesville

Location Pikesville Md.

18 (a) Funeral director John J. Heubach

(b) Address 3000 E. Baltimore St.

19 (a) (Date received by registrar) JAN 31 1947 (b) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 30 1947 at 9:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1947 to Jan 30 1947 and that I last saw him alive on Jan 30 1947

| Immediate cause of death | Duration |
|---|---|
| Cardio-respiratory failure | |
| Due to Pericarditis | |
| Due to Chr. Glomerulo-nephritis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Pericarditis, Nephritis

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. S. Hollis M.D.

Address St. Josephs Date signed 1/30/47 M. D.

G48119 BC# G54467

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

157E

Registered No. G48119

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Baseine Sts
(c) Hospital or institution: Municipal Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2305 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Thomas F. & Barry Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 46

| 8. AGE: Years | Months | Days | If less than one day: hrs. | min. |
|---|---|---|---|---|
| | 4 5 | | | |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name Thomas F. Mrs Barry.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary M. Unsworth.
15. Birthplace Balto. Md.

16 (a) Informant John F. McBurney
(b) Address 1341 Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/47 (day) (year)
(c) Cemetery or crematory Mt. Lotts.
Location Old Frederick Rd.

18 (a) Funeral director John. G. Moran
(b) Address 4320 Greenmount Ave

19 (a) (Date received by local registrar) (b) [illegible] (Registrar)

JAN 31 1947

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan. 30 1947; at 2 45 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 29 1947, to Jan 30 1947, and that I last saw him alive on Jan 30 1947.

Immediate cause of death: Congenital heart disease
Patent interventricular septal defect — Duration: Since birth
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
Signature Charles R. Johnson M.D.
Address Univ. Hosp. Date signed 1/30/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

G48120 147106 CERTIFICATE OF DEATH 180

G48120 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 815 E Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ernestine DUNN

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | Child |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1942

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 4 | 9 | 10 | hr. min. |

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Dunn
13. Birthplace N. C.

MOTHER
14. Maiden Name Fannie Lee Pittman
15. Birthplace N. C.

16 (a) Informant Charles Dunn
(b) Address 128 S. High St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-3-47 (month) (day) (year)
(c) Cemetery or crematory M. T. Calvary Cemetery
Location Cedar Hill Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) (Date received by Registrar) (b) Registrar
JAN 31 1947
Huntingtown Williamsport, Md.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 30 1947, at 3:45 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carbon Monoxide Poisoning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-30-47 at 3:30 3/2 P M.
(b) Where did injury occur? 815 E. Pratt St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Conflagration of house

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 1/30/47

X

PG 18121

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 57

Registered No. G18121

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address West Balto General
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2551 Robb St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** MARY L. CLARK

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife William Lee Clark
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) May 5 1899

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 47 | 8 | 24 | hr. min. |

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Thatcher Bell
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Jane Chilcott
15. Birthplace Baltimore Md

16 (a) Informant William Lee Clark Jr
(b) Address 2551 Robb St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director John C. Miller Inc
(b) Address 1125 E Oliver St

JAN 31 1947 (Date rec'd by registrar) Baltimore, Md.

## MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 29, 1947 at 4 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27 1946 to 1/29 1947, and that I last saw HER alive on 1/25 1947.

Immediate cause of death CAUSE UNDETERMINED, PROBABLY BRAIN TUMOR — Duration

Due to

Due to

Other Conditions DIVERTICULOSIS COLON (Include pregnancy within 3 months of death)

Date of operation 1/28/47

Major findings of operation: INCREASED INTRACRANIAL PRESSURE

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Rubinstein M. D.
Address 3706 Rogdale Rd Date signed 9/29/47

VS 150

G18122

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 467

Registered No. G18122

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3104 Brighton st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3104 Brighton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Rosalie M. Finnan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband Eugene V. Finnan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 16th 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 6 | 14 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Gustave V. LeFaivre
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary A. Phelan
15. Birthplace Ireland

16 (a) Informant Eugene V. Finnan Jr.
(b) Address 137 E. North Ave

17 (a) Burial (b) Date thereof 2/3/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 217 St. Paul St

FEB 1 - 1947 (Date rec'd by Registrar) (By) Huntington Williams M.D. (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30th 1947, at 12 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1946 to Jan 30 1947, and that I last saw h[illegible] alive on Jan 30 1947.

| Immediate cause of death | Duration |
|---|---|
| Myocardial insufficiency | |
| Due to Generalized Carcinomatosis | 6 months |
| Due to Carcinoma of rectum | 2 yrs. |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2901 Eldersloe Rd. Date signed Jan 31 47

VS 150

X

Chelton

G48123

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48a

Registered No. G48123

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 601 E 41st St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 E 41st St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Louise E. Chelton

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Wilhom H

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 24 1901

8. AGE: Years 45 | Months 11 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Stenographer

11. Industry or business Shuteroff Corp

FATHER
12. Name Wilhom Grodt
13. Birthplace Germany

MOTHER
14. Maiden Name Emma Lospahan
15. Birthplace Baltimore Md

16 (a) Informant Wm G Chelton
(b) Address 601 E 41st St

17 (a) Burial
(Burial, cremation, or removal) (b) Date thereof 2/3/47
(month) (day) (year)

(c) Cemetery or crematory Oak Lawn
Location Baltimore Md

18 (a) Funeral director Wilhom Corp Inc
(b) Address 1219 Light St

19 (a) FEB 1 1947 (b)
(Date rec'd by Registrar) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 29 1947, at 10 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Jan. 29 1947, and that I last saw her alive on Jan. 29 1947

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of Cervix | 3 yrs. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Kammer, Jr. M. D.
Address 501 Sheridan Ave. Date signed 2/4/47

X

G18124

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

Registered No. G18124

'PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2101 Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Cold Spring Lane (If no No. give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John M. Ritter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband~~ or wife: Gertrude E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 12th 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 11 | 19 | hr. min. |

9. Birthplace N. Y. (Town, county, and state)
10. Usual Occupation Safe Expert
11. Industry or business Self

FATHER
12. Name Richard Ritter
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Klausman
15. Birthplace Germany

16 (a) Informant Mrs. Gertrude Ritter
(b) Address 2111 Allendale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

FEB 1 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31st 1947, at 11:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1946, to Jan. 31 1947, and that I last saw h~~im~~er alive on Jan 30 1947.

| Immediate cause of death | Duration |
|---|---|
| Pneumonia - (Broncho) | 4 days. |
| Due to Cerebral Hemorrhage | 5 mo. |
| Due to Hypertensive Cardio Vasc. or Disease | ? - |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R. Kleiman M. D.
Address 3803 Edmondson Ave Date signed 1/31/47

G48125

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13a

Registered No. G48125

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Longland and Freeman
(c) Hospital or institution: University Hosps - Baltimore Md
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mon., or days) 19 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 N. Hilton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Alice P. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Eugene B. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1872

8. AGE: Years 74 | Months 7 6 | Days | If less than one day hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Henry Cramer
13. Birthplace Pa.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Eugene H. Smith
(b) Address 700 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) FEB 1 - 1947 (Date rec'd by registrar) (b) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 31 1947, at 4 00 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2/1947 to 1/31/1947 and that I last saw her alive on 1/21/1947

Immediate cause of death Bronchopneumonia Duration 10 days

Due to Subacute and Chronic Nephritis

Due to Uremia.

Other Conditions Benign Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Lee H. Wilson
Address Baltimore, Md. Date signed 1/31/47 M. D.

G18126

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 107

Registered No. G18126

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 809 Newington Ave.
(c) Hospital or institution: 13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 809 Newington Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

**3 (a) FULL NAME** TILLIE ADLER

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Herman S. Adler.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1861.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 85 | 1 | 14 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER
12. Name Leopold Frankel,
13. Birthplace Germany.

MOTHER
14. Maiden Name Henriette Lansburgh,
15. Birthplace Germany.

16 (a) Informant Mrs. Eileen Goldsmith,
(b) Address 809 Newington Ave.

17 (a) Burial (b) Date thereof 2.2.47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom Cem.
Location Balto. Md.

18 (a) Funeral director Harris Levindale Hoos
(b) Address 1902 Eutaw Place.

FEB 1 - 1947 (b) Huntington Mills Registrar
(Date rec'd by Registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31st. 1947, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1943 to Jan. 31 1947.
and that I last saw h alive on Jan. 31 1947.

| Immediate cause of death | Duration |
|---|---|
| Bronchio-pneumonia | 2 days |
| Due to Senility - arteriosclerosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bernard Cohen M. D.
Address Marlborough Apts Date signed

G48127 Brith Certificate

JL - 107804 46 9014

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

159

Registered No. G48127

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1604 Eutaw St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Girl Runyan- Mildred

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1947

8. AGE: Years | Months | Days: 1 | If less than one day: 22 hr. 16 min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Runyan
13. Birthplace Pa.

MOTHER
14. Maiden Name Mildred Jackson
15. Birthplace W. Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 1-24-47 (month) (day) (year)
3pm
(c) Cemetery or crematory B. C. H.
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) Date rec'd by local registrar FEB 1 1947 (b) Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23 1947, at 10.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 22 1947 to Jan. 23 1947 and that I last saw h[illegible] alive on Jan. 23 1947

Immediate cause of death: Prematurity — Duration: Life

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes M. D.

Address Balto City Hosp Date signed Jan 27 47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

648128

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

Registered No. 648128

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 700 W. Ho^th St.,
(c) Hospital or institution:
Home for Incurables 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 11
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. Ho^th St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary L. Fischer

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Frederick Fischer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 9, 1859

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 87 | 3 | 22 | hr. min. |

9. Birthplace Frederick, Md.
(Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name John M. Berger
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Seaman
15. Birthplace Frederick, Md.

16 (a) Informant Jane C. Adamson Supt.
(b) Address 700 W. Ho^th St. Baltimore 11, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 3/1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location Balto

18 (a) Funeral director Welsh Funeral Home
(b) Address 2948 Oleans St

19 (a) FEB 1 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 8

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 31, 1947, at 8 35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1st 1938 to Jan. 31st 1947, and that I last saw h^er alive on June 30 1947

| | Duration |
|---|---|
| Immediate cause of death Congestive Heart Failure | 2 days |
| Due to Hypertensive C. Vasc. Dis. | 20 yrs |
| Due to | |
| Other Conditions Old Healed Fracture Inspiration Bronchopneumonia (Include pregnancy within 3 months of death) | 15 mos. |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Conrad Wolf M. D.
Address 11 E. Chase St. Date signed 1/31/47

Death Certificate

648129 M-69289

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 161c

Register 648129

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1346 Division St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1346 Division St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** VASHTI EVANS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/30/47

8. AGE: Years | Months | Days 1 day | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name James Evans
13. Birthplace Md

MOTHER 14. Maiden Name Catherine Jones
15. Birthplace Md

16 (a) Informant Mrs. Catherine Evans
(b) Address 1346 Division St.

17 (a) Buried (b) Date thereof 2-1-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mc Frances H. Hensley
(b) Address 518 (W.) Biddle St.

19 (a) FEB 1-1947 Cunningston Williams, M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 31, 1947, at 2½ P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30, 1947, to Jan 31 1947, and that I last saw him or alive on Jan 30 1947

| Immediate cause of death | Duration |
|---|---|
| Acute Hemorrhagic Anemia of The Newborn | 1 Day |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice Adams, M. D.
Address 238 N. Carey St Date signed 1-31-47

VS 8

G48130

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 467

Registered No. G48130

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 438 N. Fremont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 8
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 438 N. Fremont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Porter

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Louise

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1894

8. AGE: Years 52 | Months 3 | Days 27 | If less than one day hr. min.

9. Birthplace St. Mary's Co. Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Alberta Monroe
(b) Address 1319 N. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 1, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lee H. Stallard
(b) Address 1651 Druid Hill Ave.

FEB 1 - 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-30-1947 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15-1947 to 1-30 1947, and that I last saw h[illegible] alive on 1/29 1947.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 6 mos.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature H. A. Jackson
Address Cash Advance signed 3/1/47

VS 150

G48131

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 F

Registered No. G48131

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 405 E. 24th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 E. 24th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Mary A. Scott

3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 4, 1881
8. AGE: Years 66 | Months - | Days 25 | If less than one day hr. min.
9. Birthplace Richmond, Va (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Charles Scott
13. Birthplace Hanover Co. Va

MOTHER
14. Maiden Name Jenkins
15. Birthplace

16 (a) Informant Mrs. Bertha M. Scott
(b) Address 405 E. 24th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 1, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Wm. H. Holland
(b) Address 1631 Druid Hill Ave.

19 FEB 1 - 1947 (Date rec'd by registrar) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 29 1947, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 25 1947 to Jan 29 1947 and that I last saw h[illegible] alive on Jan 27 1947.

Immediate cause of death: Carcinoma Rec — Duration: 1 yr
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home or on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ivan B. Jolcan
Address 2729 Sarepta St. Date signed Jan 29 47

VS 150

G48132

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1310

Registered No. G48132

PLEASE WRITE PLAINLY; WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 920 N. Arlington Ave.
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 920 N. Arlington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mariah Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 13 1881

8. AGE: Years 65 | Months 1 | Days 18 | If less than one day: hr. min.

9. Birthplace Halifax Co. Va (Town, county, or state)

10. Usual Occupation Domestic

11. Industry or business

12. Name of Father: Daniel Blaine
13. Birthplace of Father: Virginia
14. Maiden Name of Mother: Sykie Moore
15. Birthplace of Mother: Virginia

16 (a) Informant: Mrs. Ollie A. Lyon
(b) Address: 3845 Hereford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 3, 1947 (month) (day) (year)
(c) Cemetery or crematory: Arbutus Mem. Pk.
Location: Arbutus Mem. Park.

18 (a) Funeral director: Geo. H. Stylland
(b) Address: 1631 Druid Hill Ave.

19. Filed (Date filed) (Registrar) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1-30-1947, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-27-1947, to 1-30 1947, and that I last saw her alive on 1-30 1947.

| Immediate cause of death | Duration |
|---|---|
| Rt. Hemi plegia, Cardio-Renal Disease | |
| Due to Hypertensive myocardial failure | 1 yr. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Harmon M. D.
Address 1001 N. Arlington Ave. (Signed)

VS 150

C48133 JL - 105912

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 83c

Registered No. C48133

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 24
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4670 Falls Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Maude Luvenia Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | Married |

6 (b) Name of husband or wife John Wesley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 9 | 16 | hr. min. |

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Williams
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Scott
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Feb. 3, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Johns
Location Baltimore Co. Md.

18 (a) Funeral director Geo. H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) FEB 1 - 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31 1947, at 8.10A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 1946, to Jan. 31 1947, and that I last saw h[illegible] alive on Jan. 31 1947.

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia | 1 wk |
| Due to | |
| Due to | |
| Other Conditions Glaucoma 2d cerebral softening (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy: no chance

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.
Address Balt. City Hosp. Date signed 1/31/47

VS 150

107

G48134

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G48134

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 124 days
(e) Length of stay in Baltimore (yrs., mos., or days) 124 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Vt. (b) County
(c) City or town Springfield
(If outside city or town limits, write RURAL and give town)
(d) Street No. RFD #6 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Davidson, Floyd Leslie

3 (b) If veteran, name war
3 (c) Social Security Account No. 540-03-8303

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1906

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 40 | 9 | 26 | hr. min. |

9. Birthplace Rutland, Vermont (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Seafarer

FATHER
12. Name Leslie E. Davidson
13. Birthplace Springfield, Vermont

MOTHER
14. Maiden Name Helen Preston
15. Birthplace Wallingford, Vermont

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-47 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Arlington Presbyterian Cemetery Inc

18 (a) Funeral director Acker Funeral Home Inc
(b) Address 403 E. 25th St.

19 (a) FEB 1 - 1947 (Date rec'd by registrar) (b) Huntington & Williams

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 28 1947, at 7:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 26 1946 to Jan. 28 1947 and that I last saw him alive on Jan. 28 1947

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of lung with numerous metastases left lobe | UNKNOWN |
| Due to (2) Bronchiectasis left lung | UNKNOWN |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 1/30/47 M. D.

VS 150

G48135

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 47c

Registered No. G48135

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully noted. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Sinai Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2812 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME JOSEPH C. BERRY (Joseph LaBlanc Berry)

3 (b) If veteran, name war.....

3 (c) Social Security Account No. 219-01-8263

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Anna Berry
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 20, 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 9 | 10 | ..... hr. ..... min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Self

FATHER
12. Name Benjamin Berry
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Florence Wonn
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Mary Berry
(b) Address 3932 Edmondson Ave.

17 (a) Burial (b) Date thereof Feb. 3, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miles L. Murray
(b) Address 510 Liberty Heights Ave.

FEB 1 - 1947 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/30 1947, at 6 55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/27 1947, to 1/30 1947, and that I last saw him alive on 1/30 1947.

| Immediate cause of death | Duration |
|---|---|
| Bronchogenic Carcinoma. | |
| Due to..... | |
| Due to..... | |
| Other Conditions..... | |

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy: Carcinoma - lungs, mets to kidneys, spleen, bladder.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Stanley N. Yoh M.D.
Address Sinai Hosp. Date signed 1/30

VS 150

G48136

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 92 B

G48136 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 307 S. Sharp St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Charles E. Siegmund

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Carrie Belle Siegmund
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1869

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 8 | 6 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business Self

FATHER
12. Name Gustav Siegmund
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Entner
15. Birthplace New York

16 (a) Informant Mr. Harry B. Siegmund
(b) Address 4109 Chatham Road

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Feb. 1, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director
(b) Address 4510 Liberty Heights Ave.

FEB 1 - 1947 (Date rec'd by local registrar) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 30 1947, at 7.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 26 Oct 1946 to 30 Jan 1947. and that I last saw h[illegible] alive on 30 Jan 1947

| Immediate cause of death | Duration |
|---|---|
| Acute Pulmonary Edema | |
| Due to Rheumatic Heart Disease | |
| 2 Mitral Stenosis + Insufficiency | |
| Due to 3 Healed Sub Acute Bacterial Endocarditis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R E Barnes M. D.
Address Univ. Hosp Bd Date signed 31 Jan 47

VS 150

X

G48137

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 45c

Registered No. G48137

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3300 W. 33rd St. + Calvert St
(c) Hospital or institution: Union Mem. Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 23 years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3801 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME (GILPIN, ARTHINGTON, JR.) (Arthington Gilpin Jr)

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| NO | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife GRACE MUNNIKHUYSEN ARTHINGTON
6 (c) If alive, give age 5 years

7. Birth date of deceased (mo., day, yr.) AUGUST 4 1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 6 | 5 | 27 | hr. min. |

9. Birthplace Williamsport, Pa.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Coudrington Gilpin
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Caroline Cope
15. Birthplace Pennsylvania

16 (a) Informant Son - GILPIN, ARTHINGTON III
(b) Address 3801 N Charles St.

17 (a) Burial (b) Date thereof Feb 3 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md.

18 (a) Funeral director Henry D. Jenkins (Asst.)
(b) Address McCulloh Richardson
(c) FEB 1 - 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 31 1947, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30 1947, to Jan 31 1947, and that I last saw h[illegible] alive on Jan 31 1947.

| Immediate cause of death | Duration |
|---|---|
| Hemorrhage from erosion of cervical artery | 1 da |
| Due to Squamous Cell carcinoma of floor of mouth | 17 mos |
| Due to | |
| Other Conditions Hypertension Cardiovascular disease | |

(Include pregnancy within 3 months of death)
Date of operation Dec 5, 1946
Major findings of operation: (Radon implant)
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman M.D.
Address Union Memorial Hosp Date signed 1/31/47

VS 150

G48138

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 74a

Registered No. G48138

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Carroll
(c) City or town Finksburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Joann Mann

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | S |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5 - 1845

| 8. AGE: Years | Months | Days | If less than one day: hr. | min. |
|---|---|---|---|---|
| 1 | 20 | 26 | | |

9. Birthplace Carroll County Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name James Mann
13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Ann Bell
15. Birthplace Maryland

16 (a) Informant James Mann
(b) Address Finksburg Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 3 '47 (month) (day) (year)
(c) Cemetery or crematory Wesley
Location Sandall Co Md

18 (a) Funeral director Edw C Tipton
(b) Address Hampstead Md

19 (a) Filed FEB 1 1947 (b) Registrar

(Date filed by Local Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 11/31/46 19 , at 3 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/22 1947, to 11/31 1947, and that I last saw her alive on 11/31 1947.

| Immediate cause of death: Acute Leukemia | Duration |
|---|---|
| Due to | |
| Due to | |
| Other Conditions: Pneumonia | |

(Include pregnancy within 3 months of death)

Date of operation: one
Major findings of operations:
Autopsy: 11/31/47

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Nasenberg Jr. M.D.
Address University Hosp Date signed 12/1/47

VS 150

G48139 HEALTH DEPARTMENT—CITY OF BALTIMORE G48139

CERTIFICATE OF DEATH ✓ 94a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4315 Harford Road St., ✓ Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ...yrs. ...mos. ...ds. How long in U. S. If of foreign birth? ...yrs. ...mos. ...ds.

2. FULL NAME Charlotte L. Wagner ✓

If U.S. Veteran specify WAR.....

(a) Residence: No. 4315 Harford Road St., ...Ward,
(Usual place of abode) (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. Color or Race | 5. Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| female | white | married |

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Henry F. Wagner

6. DATE OF BIRTH (month, day, year) June 25, 1886

| 7. AGE Years | Months | Days | If LESS than 1 day, ...hrs. or ...min. |
|---|---|---|---|
| 60 | 7 | 6 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. at home

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

FATHER

13. NAME Dennis PL Disney

14. BIRTHPLACE (city or town) Md.
(State or country)

MOTHER

15. MAIDEN NAME Mary Rebecca ?

16. BIRTHPLACE (city or town) Md.
(State or country)

17. INFORMANT Mr. Henry F. Wagner
(Address) 4315 Harford Road -14-

18. BURIAL, CREMATION, OR REMOVAL
Place Loudon Park Date Feb. 3rd-47

19. UNDERTAKER Leonard J. Ruck
(Address) 5305 Harford Road

20. FILED FEB 1 - 1947 Huntington Williams M.D.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 1/31, 1947

22. I HEREBY CERTIFY, That I attended deceased from 1/31, 1947 to 1/31, 1947

I last saw her alive on 1/30, 1947 Death is said to have occurred on the date stated above, at 5-15 A m.

The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Coronary Thrombosis | 1/31/47 |
| | |
| | |
| | |
| Other contributory causes of importance: | |
| | |

Was an operation performed? No Date of.....

For what disease or injury?.....

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? No Date of injury....., 19...

Where did injury occur?.....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.....

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify.....

(Signed) Walter E. Hopkins M. D.

(Address) 4331 Harford Rd.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact OCCUPATION is very important. See instructions on back of certificate.

48140

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 95R

Registered No. G48140

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Union + Caroline
(c) Hospital or institution:
St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) hrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7511 Old Harford Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Douglass J. Snyder

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | MARRIED |

6 (b) Name of husband or wife Gwendolyn H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/1/07

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 39 | 4 | 30 | hr. min. |

9. Birthplace Baltimore Md (town, county, and state)
10. Usual Occupation Grocer
11. Industry or business Grocery Business

FATHER
12. Name Charles A. Snyder
13. Birthplace Md

MOTHER
14. Maiden Name Irene Jackson
15. Birthplace Md

16 (a) Informant Mrs. Gwendolyn Snyder
(b) Address 7511 Old Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Road.

19 (a) FEB 1 1947 (Date rec'd by Registrar) (b) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/31 1947, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/31 1947, to 1/31 1947 and that I last saw him alive on 1/31 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral Embolism | |
| Due to | |
| Subacute Bacterial Endocarditis | |
| Due to | |
| Other Conditions | |
| Chronic Interstitial Nephritis | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard A. Young M. D.
Address St. Josephs Hosp. Date signed 1/31/47

Spec.—1-10-21—M&T—1500 Blks.

G48141

# HEALTH DEPARTMENT—CITY OF BALTIMORE

G48141

## CERTIFICATE OF DEATH. 16

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Kernan Hospital 1601 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes White

(a) RESIDENCE NO. Ward 7 Dept of Welfare 1795 Harlem ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| F | NEGRO | SINGLE |

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-9-34

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 12 | 7 | 21 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work student

(b) General nature of industry, business, or establishment in which employed (or employer) NONE

(c) Name of employer NONE

9 BIRTHPLACE (city or town) (State or country) unknown

PARENTS

10 NAME OF FATHER Bernard White

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant (Address) Records Kernan Hospital Baltimore 7, Maryland

15 Filed FEB 1 - 1947 Huntington Williams M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-30 1947

17

I HEREBY CERTIFY, That I attended deceased from June 24, 1946, to January 30, 1947, that I last saw her alive on January 30, 1947, and that death occurred, on the date stated above, at 12 45 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, bone involving left elbow, wrist & ankle and lower dorsal upper lumbar vertebrae

(duration) 3 yrs. mos. da.

CONTRIBUTORY (Secondary) Malnutrition.

(duration) 3 yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) Geo B Bandle M. D.

, 19 (Address) Kernan Hospital Balto 7, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters cemetery

DATE OF BURIAL 2/3/1947

20 UNDERTAKER Elroy O. Wilson

ADDRESS 1000 Brent Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement—OCCUPATION is very important. See instructions on back of certificates.

G48142

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

Registered No. G48142

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5006 Dennmore Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5006 Dennmore Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Miriam C. Buttner

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife William J. Buttner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 7 | 27 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

| | |
|---|---|
| FATHER | 12. Name Geo W. Clarke |
| | 13. Birthplace Balto Md |
| MOTHER | 14. Maiden Name Mollie B. Buckheimer |
| | 15. Birthplace Balto Md |

16 (a) Informant Mr. William J. Buttner
(b) Address 5006 Dennmore Ave

17 (a) Burial (b) Date thereof Jan 1, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore

18 (a) Funeral director Loring Byers
(b) Address 5005 Park Heights Ave

19 (a) Date received by Local Registrar 1947 (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 30, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/30 1945 to 1/30 1947 and that I last saw h[illegible] alive on 1/28 1947

Immediate cause of death: Carcinoma of the breast. — Duration

Due to

Due to

Other Conditions metastasis

(Include pregnancy within 3 months of death)

Date of operation 1945

Major findings of operation: Ca of breast

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A. Armstrong
Address 1613 Eastern Ave Date signed 1/30/47

VS 150

G48143 BC# G68267 /108

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G48143

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 511 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Paul Joseph Schmidtchen

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1947

8. AGE: Years | Months | Days: 17 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Walter Schmidtchen
13. Birthplace Balto.

MOTHER
14. Maiden Name Gianna Liberto
15. Birthplace Balto. Md.

16 (a) Informant Hosp. Rec'd
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 1 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Windsor Road

18 (a) Funeral director Joseph Fararo & Son
(b) Address 1613 Stranmount Ave

19 (a) Filed (b) Huntington Williams, M.D. Registrar
FEB 1 1947

VS 130

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 1, 1947 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-31 1947 to 2-1 1947 and that I last saw him alive on 2-1 1947

| Immediate cause of death | Duration |
|---|---|
| respiratory failure | 1 day |
| Due to Bilateral massive pneumonia | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James J. Garlach M. D.
Address Mercy Hosp. Date signed 2-1-47

X

G48144

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 61

G48144
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 W Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County Howard Co.
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Edward Taylor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years: 74 | Months | Days | If less than one day: hr. min.

9. Birthplace Carroll Co. Md.
(town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER 12. Name unknown
13. Birthplace unknown

MOTHER 14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Frank Taylor
(b) Address 712 Thurman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 4 (month) (day) 1947 (year)

(c) Cemetery or crematory Mt. Hope
Location Mt. Carroll Carroll Co. Md.

18 (a) Funeral director H. M. Lutz & Son
(b) Address Mt. Airy

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 2 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 2-1 1947, at 10:45 A.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from 1/19 1947 to 2/1 1947 and that I last saw h[illegible] alive on 2/1 1947.

Immediate cause of death: Cardiac failure — Duration

Due to: Gangrene of left foot

Due to: Diabetis mellitus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Gangrene of foot

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23. Signature** Julian Jaworski M. D.

Address St. Jos. Hosp. Date signed 2/1/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48145

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 55E

G48145 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland Sinai Hospital
(b) Street address Monument & Rutland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702 Whitelock St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lillian Sapiro

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Israel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1898

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 48 | 9 | 19 | hr. min. |

9. Birthplace Winchester Va
(Town, county, and state)

10. Usual Occupation
11. Industry or business House Wife

FATHER
12. Name Louis Levin
13. Birthplace Russia

MOTHER
14. Maiden Name Yetta Berman
15. Birthplace Russia

16 (a) Informant Israel Sapiro
(b) Address 702 Whitelock

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb, 2, 1947 (month) (day) (year)
(c) Cemetery or crematory Arlington Park Cemetery
Location Rogers Ave

18 (a) Funeral director Sol, Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) 2 1947 (Date filed by registrar) (b) Registrar

V S 150

Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-31-47 1947, at 11 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-23- 1947, to 1-31 1947, and that I last saw her alive on 1-22-1947.

Immediate cause of death Respiratory failure — Duration

Due to Lymphosarcoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bertha Raden M. D.
Address Sinai Hospital Date signed 1-31-47

X

G48146

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

G48146 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1810 N Payson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 No Payson St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Israel Bucknen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jennie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER 12. Name Solomon

13. Birthplace Russia

MOTHER 14. Maiden Name Esther

15. Birthplace Russia

16 (a) Informant Jennie Bucknen

(b) Address 1810 No Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-47 (month) (day) (year)

(c) Cemetery or crematory Helen Memorial Park

Location

18 (a) Funeral director Jack Levin Inc

(b) Address 1432 E Baltimore St

19 (a) Date received by registrar FEB 2 1947 (b) Registrar Huntington Williams M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2-1-1947 at 1A M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov. 5, 1946 to Feb. 1, 1947 and that I last saw him alive on 1/31/47 1947

Immediate cause of death: Coronary Insufficiency Myocardial Failure — Duration: about 3 months

Due to: Hypertension.

Due to: Nephritis Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathaniel Stanley Hed. M.D.

Address 1810 Eutaw Pl. Date signed 2/1/47

G48147

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G48147
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 808 NEWINGTON AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 39 YRS

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 808 NEWINGTON AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DORA KERBEL
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| FEMALE | WHITE | MARRIED |

6 (b) Name of husband or wife MAX
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | | | hr. min. |

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name ABRAHAM
13. Birthplace RUSSIA

MOTHER
14. Maiden Name KATIE
15. Birthplace RUSSIA

16 (a) Informant MAX KERBEL
(b) Address 808 NEWINGTON Ave
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-2-47 (month) (day) (year)
(c) Cemetery or crematory BEBREN Young Mens
Location WINDSOR HILL RD
18 (a) Funeral director VOCK LEWIS INC
(b) Address 1439 E. BALTO. ST.
19 (a) 2 1947 (Date received by registrar) (b) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/2/47 19... at 7:30 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 12, 1947 to Feb. 1, 1947, and that I last saw her alive on 1/31/47, 19...

Immediate cause of death: Coronary Occlusion. — Duration: about 2 wks.
Due to
Due to
Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Nathan H. Kantrowitz, M.D.
Address 1810 Eutaw Pl. Date signed 2/1/47

Huntington Williams, MD

X

G48148

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G48148 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution Sinai Hospt

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2023 E. Balto St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAX SUSDICK

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widow |

6 (b) Name of husband or wife Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hyp Resnick
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-47 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Philadelphia Baltimore Lane
18 (a) Funeral director Joseph Levin Inc
(b) Address 1439 E. Balto St
19 (a) 2947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/31 1947, at 5:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/27 1947 to 1/31 1947, and that I last saw him alive on 1/29 1947

| Immediate cause of death | Duration |
|---|---|
| Coronary Occlusion | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address Sinai Hosp Date signed 2/5/47 M. D.

VS 150

G48149

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G48149 No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins & Eaton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 33 S. Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Laura S Steffey (STEFFIE)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex 7

5. Color or race W

6 (a) ~~Single, married~~, widowed, or divorced ~~—~~ Widowed

6 (b) Name of husband or ~~wife~~ Charles A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29 1874

8. AGE: Years 72 | Months 6 | Days 2 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business At Home

FATHER 12. Name Phillip D. Getland Deceased

13. Birthplace Md. Va.

MOTHER 14. Maiden Name Elizabeth Wright Deceased

15. Birthplace Md. W. Va.

16 (a) Informant Bessie E. Pickett

(b) Address 120 S. Calvert St (Daughter)

17 (a) Burial (b) Date thereof 2/3/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-31 1947, at 9:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-26 1947, to 1-31 1947, and that I last saw h[illegible] alive on 1-31 1947

| Immediate cause of death | Duration |
|---|---|
| Cardiac Failure | |
| Due to Coronary Occlusion with Myocardial infarction | |
| Due to | |
| Other Conditions Cerebral embolism | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry W. Höllies M. D.

Address St. Agnes Hosp. Date signed 1-31-47

VS 150

G48150

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48150 Registered No. 54B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 314 W. Lorraine Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 314 W. Lorraine Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles Wm Roseberry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Pearl V.

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Oct 21st 1898

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 48 | 3 | 9 | ..... hr. ..... min. |

9. Birthplace: Pulaski Va.
(Town, county, and state)

10. Usual Occupation: Yard Master

11. Industry or business: Pa. R. R.

FATHER
12. Name: Sidney Bruce Roseberry
13. Birthplace: Va.

MOTHER
14. Maiden Name: (Unknown) Hewett
15. Birthplace: Va.

16 (a) Informant: Mrs Pearl Roseberry
(b) Address: 314 W. Lorraine Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/3/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~: New Freedom
Location: New Freedom Pa.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St.

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH (Month) Jan 30th (Day) 1947, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 6 1947 to Jan 30 1947 and that I last saw ~~him~~ alive on Jan 30th 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral Carcinoma | 2 mo. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Wm H. Pearce M. D.
Address 2105 Eutaw Date signed Feb 5/47

VS 150

G48151

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 104

G48151 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 840 N. Eutaw St
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mo

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 840 N. Eutaw St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Virginia S. GROSS

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife James F. Gross
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) July 11-1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | 6 | 19 | hr. min. |

9. Birthplace Job. W. Va.
(Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name George Kerens
13. Birthplace W. Va.

MOTHER
14. Maiden Name Martha White
15. Birthplace W. Va.

16 (a) Informant James F. Gross
(b) Address 840 N. Eutaw St

17 (a) Removal (b) Date thereof Feb. 3. 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Elkins W. Va.

18 (a) Funeral director Mrs. Mrs. John W. Teufel & Son
(b) Address 5301 Edmondson Ave

B 2 1947 (c) Huntington Williams
(Date rec'd by registrar)

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 1947, at 1:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George C. Merrill M.D.
Medical Examiner.
Date signed 1/31/47

G48152

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

P-G48152 Registered No. 46 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 229 N Lakewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 229 N Lakewood Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Herman F Morgereth

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of [redacted] or wife Dora Morgereth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 31 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 71 | - 11 | - 29 | hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Retired Sun Paper Carrier
11. Industry or business A S ABell Co. Sun Paper

FATHER
12. Name F Morgereth
13. Birthplace Germany

MOTHER
14. Maiden Name A Flottermisch
15. Birthplace Germany

16 (a) Informant Mrs Dora Morgereth
(b) Address 229 N LaKewood Ave -

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Fredwpick Rd.

18 (a) Funeral director Milton A Sullivan Jr
(b) Address 3914 Hanover Street -25-

19 (a) 1947 (Date rec'd by registrar) (b) [illegible] Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 30th 1947 at 2.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 29 1947 to Jan 30 1947 and that I last saw h[illegible] alive on Jan 30 1947

Immediate cause of death Carcinoma of stomach — Duration 2 yrs.

Due to

Due to

Other Conditions Extreme emaciation dehydration
(Include pregnancy within 3 months of death)

Date of operation Dec. 1945

Major findings of operation: Carcinoma of stomach Circumscribed

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 4218 Harford Rd. Date signed 3 Jan. 47

VS 156

G48153

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

122a

G48153

Registered No.

Every item of information should be carefully supplied. The correctness is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address 1400 N Caroline St

(c) Hospital or institution: St Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day

(e) Length of stay in Baltimore (yrs., mos., or days) 77 yrs

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md (b) County

(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 148 N Streeper St (If rural give location)

(e) Citizen of foreign country? Ono (Yes or No)
If yes, name country

**3 (a) FULL NAME** John B. Steigerwald.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M. | W | Married |

6 (b) Name of husband or wife Mary.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1 2 40

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | - | 29 | hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Retired.

11. Industry or business

**FATHER**

12. Name Conrad Steigerwald

13. Birthplace Balto. Md.

**MOTHER**

14. Maiden Name Hanna Dilroe

15. Birthplace Balto. Md.

16 (a) Informant Mary. Steigerwald

(b) Address 143 N. Streeper St

17 (a) Burial (b) Date thereof 2/4/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Red. Cem.

Location Belair Rd.

18 (a) Funeral director John A. Ingram

(b) Address 600 E. Balto. St.

FEB 2 - 1947 Washington Williams
(Date rec'd by registrar) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/31 1947 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/30 1947 to 1/31 1947 and that I last saw h alive on 1/31 1947.

Immediate cause of death Cardio respiratory failure

Due to Ruptured Stomach

Due to Strangulated inguinal hernia, direct Rt

Other Conditions

| Duration |
|---|
| |
| |
| |
| |

(Include pregnancy within 3 months of death)

Date of operation 1/31/47.

Major findings of operation: Strangulated Inguinal hernia Direct Rt.

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature John J Ross M. D.

Address St Joseph's Hosp Date signed 1/31/47.

X

G48154

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 F

G48154 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1309 E. Belvedere Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-15
(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 E. Belvedere Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Alice Mac Famer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Harry E. Mac Famer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10-1870

8. AGE: Years 76 | Months 5 | Days 21 | If less than one day hr. min.

9. Birthplace Dalmatia Pennsylvania (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Charles C. Bowen
13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Sarah Catharine Aumiller
15. Birthplace Pennsylvania

16 (a) Informant Harry E. Mac Famer
(b) Address 1309 E. Belvedere Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 3-1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road
(c) Date received by registrar FEB 2 — 1947 Registrar's signature for Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 31- 1947, at 10-31 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from November 1946, to January 31 1947, and that I last saw her alive on 1-28 1947

Immediate cause of death: Cancer (Carcinoma) of Liver — Duration 3 mos+
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations: —
of autopsy —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Hoover Pierce M. D.
Address 312 Medical Arts Bldg Date signed 2-1-47

VS 150

G48155

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

G48155 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 74½ yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural, give location)
(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** Barbara Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | white | married |

6 (b) Name of husband or wife John Harris
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) February 14, 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 11 | 17 | hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Tailoring
11. Industry or business

FATHER
12. Name Gregory Stenger
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothy Dedio
15. Birthplace Germany

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 4 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 E. Biddle St

19 (a) 2-4-1947 (Date) (b) registrar Huntington Williams M.D.

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan 31 1947, at 7-20 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 10 - 1947, to Jan 31 1947, and that I last saw her alive on Jan 31 1947.

| Immediate cause of death | Duration |
|---|---|
| Edema Lungs | 1 day |
| Due to: Cerebral Hemorrhage | 2 days |
| Due to: | |
| Other Conditions: Arterio Sclerosis | 5 yrs |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E Monument Date signed 2/7/47

VS 3

copy of age is especially important. Physicians: please write the causes of death clearly and legibly.

G48156

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G48156 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1729 Oakland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Lavinia (Vina) Foster
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 6-10-94
8. AGE: Years 52 | Months 7 | Days 20 | If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation laundry
11. Industry or business

FATHER
12. Name Isaac Enoules
13. Birthplace Md

MOTHER
14. Maiden Name Hannah ?
15. Birthplace Md

16 (a) Informant Regarda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 2 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A A County Md

18 (a) Funeral director Mrs Robert A. Cleveden
(b) Address 1129 N. Caroline St

19 (a) (b) Date rec'd by registrar Jan 2 1947 Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 20 1947 at 8 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1946 to Jan 20 1947 and that I last saw her alive on Jan 20 1947

Immediate cause of death: Myocardial infarction — Duration: 6 wks
Due to: Coronary artery sclerosis
Due to:
Other Conditions: Diabetes mellitus acidosis, Uremia, Shock
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E. Mason M. D.
Address Johns Hopkins Hosp. Date signed 30 Jan 47

94a

G48157

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V/31a

G48157 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3712 Hillsdale Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3712 Hillsdale Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elana L. Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Eugene Harris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 6, 1860

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 86 | 4 | 25 | hr. min. |

9. Birthplace England (Town, county, and state)
10. Usual Occupation None
11. Industry or business

MOTHER / FATHER
12. Name Peter Steele Nicholson
13. Birthplace Scotland

14. Maiden Name Miss Gardner
15. Birthplace United States

16 (a) Informant Mrs. Edward Gillaspey
(b) Address 3712 Hillsdale Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 3, 1947 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Govans, Md.

18 (a) Funeral director J. Wallis Lawrence
(b) Address 4510 Liberty Heights Ave.

19 (a) Date received by registrar (b) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 31 1947, at 11.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1947 to Jan 31 1947
and that I last saw h[illegible] alive on Jan 31 1947
Immediate cause of death Coronary Occlusion
Chronic Nephritis (or) Chronic Myocarditis
Due to Hemorrhage Intracerebral
Due to Cardio Vas Disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

20 hrs. 4 hrs.
10 yrs

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos H Abbott
Address 4509 Liberty Hgts Ave Date signed 2/1/47 M.D.

2 1947 Huntington Williams, M.D.

G48158 J Bpaish

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48158 Registered No. 1131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Road
(c) Hospital or institution: Snyder's Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2807 Bayonne Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Alpha Belle Dixon

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widowed |

6 (b) Name of husband or wife Henry E. Dixon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 1 | 4 | hr. min. |

9. Birthplace Lynchburg, Virginia (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name James W. Donahoe
13. Birthplace ?

MOTHER
14. Maiden Name Isabelle Mathis
15. Birthplace ?

16 (a) Informant Mr. Wallace Dixon
(b) Address 2807 Bayonne Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/47 (month) (day) (year)
(c) Cemetery or crematory East Radford, Location Virginia

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) [illegible] (b) [illegible] (Registrar)

FEB 3 1947
VS-155

Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31st, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 6 1947, to JAN 31 1947, and that I last saw her alive on JAN 31 1947.

| Immediate cause of death | Duration |
|---|---|
| Hypostatic Pneumonia | 1½ Days |
| Due to Chronic Interstitia Nephritis with Uremia. | 15 Days |
| Other Conditions Senility. | — |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James E. White.
Address 5214 Harford Rd. Date signed 1 Feb 47

X

G48159

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

Registered No. G48159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 169 N. Gilmor St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 169 N. Gilmore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Hattie Deshields Knight

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Col. | Widow |

6 (b) Name of husband or wife B. H. Knight

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 2, 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 2 | 27 | hr. min. |

9. Birthplace Washington D. C.
(Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Henry Charles

13. Birthplace Washington D. C.

MOTHER 14. Maiden Name Priscilla Davis

15. Birthplace Washington D. C.

16 (a) Informant Blanch Kelly

(b) Address 169 Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 2 1947 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St

19 (a) (Delayed by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 29 1947 at 11:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from ~~May~~ 7-12 1946 to 1-29-1947 and that I last saw him alive on 1-29-1947

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of breast | 5 months |
| Due to Carcinoma of breast | 18 mos. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John E. S. Campbell M. D.

Address 629 N. Carey St. Date signed 2-1-47

D-1941 V S

Huntington Williams, M.D.

G48160 BALTIMORE CITY HEALTH DEPARTMENT G48160
Registered No.

# CERTIFICATE OF DEATH 153

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: Univ. Hospital
(c) Hospital or institution: Univ Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Wash
(c) City or town Hagerstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 2 Beechwood
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lois Robertson

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife Edward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1919

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 28 | | | hr. min. |

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation H W
11. Industry or business

FATHER
12. Name Clyde Middlekauff
13. Birthplace Na

MOTHER
14. Maiden Name Naomi
15. Birthplace Na

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof Feb. 5 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rose Hill
Location Hagerstown, Md.
18 (a) Funeral director C. M. Snider and Son
(b) Address Hagerstown, Md.
19 (a) (b)
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 2/2 1947, at 6 46/A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/29 1947, to 2/2 1947, and that I last saw h. alive on 2/2 1947.

| Immediate cause of death | Duration |
|---|---|
| Resp. failure | |
| Due to Disseminated Lupus Erythematosus | |
| Due to | |
| Other Conditions Pulmonary edema, anasarca | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. R. Jennings M. D.
Address Univ. Hosp. Date signed 2/2 47

FEB 3 vs 1947 Huntington Williams, Registrar

X

Birth Certificate
G48161
G-6999

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 158

Registered No. G48161

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Williams & Catlin Ave.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Halethorpe, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5729 Front Ave.
(If rural give location)
(e) Citizen of foreign country? Halethorpe (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Leibel

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1st - 1947

8. AGE: Years | Months | Days | If less than one day: 10 hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Arthur Leibel
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Somers
15. Birthplace Md.

16 (a) Informant Arthur Leibel
(b) Address 6729 First Ave. Halethorpe Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 3-1947 (month) (day) (year)

(c) Cemetery or crematory London Park
Location Baltimore, Md

18 (a) Funeral director George L. Schuntz
(b) Address 7101 Belair Ave

FEB 3 - 1947 (Date rec'd by local registrar) (b) Huntington Williams, M.D. Address St Agnes Hosp Date signed 2/2/47

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/2 1947, at 2 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1947 to 2/2 1947 and that I last saw he[r] alive on 2/2 1947.

| Immediate cause of death | Duration |
|---|---|
| (a) Prematurity | |
| Due to Unknown | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm H. Compton M.D.
Address St Agnes Hosp Date signed 2/2/47

VS 150

G48162

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G48162

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Green Street
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hours
(e) Length of stay in Baltimore (yrs., mos., or days) 8 hours

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Carroll
(c) City or town Hampstead
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** Harry Baxter Fogle

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-03-1823

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife: Mrs. Mary Fogle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 14, 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 1 | 9 | hr. min. |

9. Birthplace Carroll County Maryland
(City, county and state)
10. Usual Occupation Banker
11. Industry or business

FATHER
12. Name William Hiles Fogle
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Baxter
15. Birthplace Md.

16 (a) Informant Mrs. Mary Fogle
(b) Address Hampstead, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 6, 1947 (month) (day) (year)
(c) Cemetery or crematory Sellers Cemetery
Location Hampstead Md.

18 (a) Funeral director D D Shaffer & Son
(b) Address Main Bridge Mrs Windsor Md

19 (a) FEB 3 - 1947 (Date received by registrar) Huntington Williams

VS 2

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2-3 1947 at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2 1947, to 2-3 1947, and that I last saw h[illegible] alive on 2-3 1947

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Pulmonary embolism | |
| resulting from, mainly left lower lobe | |
| Due to Chronic pulmonary sclerosis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. L. Clark, M.D.
M. D.
Address University Hospital Date signed 2-5-47

G48163

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH
X 1937

Registered No. G48163

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Edwood & Granes Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 18 - Route 13
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Samuel Wilson McCaughey

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 192-05-9095

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Feb 17, 1893

8. AGE: Years 53 Months 11 Days 15 If less than one day hr. min.

9. Birthplace Pittsburgh Pa
(Town, county, and state)

10. Usual Occupation District Mgr.

11. Industry or business Syntron Co

FATHER 12. Name Samuel W. McCaughey

13. Birthplace Pa

MOTHER 14. Maiden Name Mary Gallagher

15. Birthplace Pa

16 (a) Informant Mrs. Helen McCaughey

(b) Address Box 18, Route 13, Essex, Md.

17 (a) Removal (b) Date thereof 2/3/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Pittsburgh, Pa

18 (a) Funeral director Wm. J. Tichnell Sons

(b) Address North & Pa. Aves

19 (a) FEB 3 - 1947 (b) Huntington Williams, Mgr.
(Date rec'd by Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/2 1947, at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/27 1947 to 2/2 1947, and that I last saw him alive on 2/2 1947.

| | Duration |
|---|---|
| Immediate cause of death: Resp. Failure | |
| Due to: Hypertension CVD. | |
| Due to: | |
| Other Conditions: Pulmonary edema | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Pomeroy Hughes M.D.

Address Univ. Hosp. Date signed 2/4/47

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48164

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 30E

Registered No. G48164

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 930 W. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH RUFFINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | ? |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | | | hr. min. |

9. Birthplace (Town, county, and state)

10. Usual Occupation Domestic Worker

11. Industry or business

FATHER
12. Name Jesse Ruffin
13. Birthplace Middleway, Virginia

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Geraldine Dixon
(b) Address 713 N. Gilmor Street

17 (a) Add (Burial, cremation, or removal) (b) Date thereof 2/4/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location West Part
Chas. H. Alexander
18 (a) Funeral director
(b) Address 1200 N. McCulloh St

19 (a) Date of registration FEB 3 - 1947 Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-1- 1947, at 12:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Syphilitic heart disease
Syphilitic aortitis
Edema of lungs

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 2/1/47

VS 191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians:- please write the causes of death clearly and legibly.

508915 G48165

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 194a

Registered No. G48165

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimor
(c) City or town Dundalk.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 112 Bolens Point Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Hubert Maya.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Black | married |

6 (b) Name of husband or wife Demented.

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) 4-9-1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | 9 | 22 | hr. min. |

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Pulp mill

11. Industry or business

FATHER
12. Name Robert Maya
13. Birthplace Va.

MOTHER
14. Maiden Name Rosina Stith
15. Birthplace Va

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 2-5-47 (month) (day) (year)
(c) Cemetery or crematory Thomas Cemetery
Location Garrisburg Md.

18 (a) Funeral director Palmer Sanders
(b) Address 1412 E Preston St.

19 (a) Filed (b) (Signature of registrar) Huntington Williams M.D. Registrar
Feb 5 1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan-31 1947, at 4.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-28 1947 to Jan-31 1947 and that I last saw him alive on Jan-31 1947.

| | Duration |
|---|---|
| Immediate cause of death Acute Dilatation | 3 Days |
| Due to Acute Dilatation of Heart | |
| Due to Abnormal intestinal infection | 3 mos. |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. J. Polowitz M.D.
Address Johns Hopkins Hospital Date signed 1-31-47

X

G48166

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 42

Registered G48166

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 weeks
(e) Length of stay in Baltimore (yrs., mos., or days) X

**2. USUAL RESIDENCE OF DECEASED:**
(a) State (b) County
(c) City or town Mexico City (If outside city or town limits, write RURAL and give town)
(d) Street No. Calle Jose de Teresa (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Mexico

3 (a) FULL NAME Elizabeth DeBreidaprecher ELIZABETH Luxes DeBreidsprecher

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Kunst

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-15-12

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 34 | 9 | 16 | hr. min. |

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Matheus Luxen
13. Birthplace Germany

MOTHER 14. Maiden Name Maria Blasius
15. Birthplace Germany

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 5-47 (month) (day) (year)
(c) Cemetery or crematory Mexico City Cem.
Location Mexico City, Mexico

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 3 - 1947 Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 1 1947 at 7 26 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 11 1947 to Feb 1 1947 and that I last saw her alive on Feb 1 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral Edema | 2 Months |
| Due to Carcinomatosis | 1 year |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 1 Feb 1947
Major findings of operation: Increased Intracranial Pressure
of autopsy: Hemorrhagic Cystadenocarcinoma

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur M. Laing M. D.
Address Johns Hopkins Hosp Date signed 2/2/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

[redacted] G48167

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 82a ✓

Registered No. [redacted] G48167

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: Redwood & Green
(c) Hospital or institution: Univ. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1hr
(e) Length of stay in Baltimore (yrs., mos., or days) —

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County A.A.
(c) City or town Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles W. Johnson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Adelaide F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27th 1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 7 | 4 | hr. min. |

9. Birthplace Balto. Md (Town, county, and state)
10. Usual occupation Asst Treasurer Bankr
11. Industry or business Mercantile Trust Co.

FATHER
12. Name Louis Johnson
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Amelia Frank
15. Birthplace Balto. Md

16 (a) Informant Adelaide F. Tiedeman
(b) Address 27 Hanover St. Annapolis Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) (Delivered to registrar) (b) Registrar

FEB 3 1947 Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1st 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6:30 PM 1947 2/1/47 7:30 PM 2/1/47 and that I last saw h alive on 2/1 19 47.

| Immediate cause of death | Duration |
|---|---|
| Pneumonia | |
| Due to Subarachnoid hemorrhage | |
| Due to Intracranial aneurysm | |
| Other Conditions hypertension | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Subarachnoid hem

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. Nichols Jr.
Address Univ. Hosp Date signed M. 2 D. 3/47

X

501 G48168

BALTIMORE CITY DEPARTMENT

# CERTIFICATE OF DEATH 157H

Registered No. G48168

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~1800 Division Ave~~ 3 Talbott Pl.
(If rural give location)
(e) ~~Citizen of foreign country~~
If yes, name country

**3 (a) FULL NAME** Thomas Paul Rainier ~~Thomas Rainier~~

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male. | White | Infant |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-14-46.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| — | 4 m. | 17 | hr. min. |

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Thomas W. Rainier
13. Birthplace Balto, Md

MOTHER
14. Maiden Name Nellie P. Parks
15. Birthplace Balto., Md

16 (a) Informant ~~Thos. Brewster~~ W. Rainier
(b) Address ~~3107 Talbott Pl, Balto, Md~~

17 (a) Burial — (b) Date thereof Feb 3, 1947
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem
Location Anne Arundel Co, Md

18 (a) Funeral director A. Raymond Evans
(b) Address 1400 E. Chase St, Balto

19 (a) (Date rec'd by Registrar) (b) Registrar

FEB 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 31 1947, at 11.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 25 1946, to Jan. 31 1947, and that I last saw him alive on Jan. 31 1947

| Immediate cause of death | Duration |
|---|---|
| Congenital Nephrosis | 4 m. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. J. Jaggard M.D.
Address Johns Hopkins Hospital Date signed Feb 1, 1947

X

G48169

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 178a

Registered No. G48169

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 W. Barney St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leo. Moro Da Pozzo OR Ermino Da Pozzo

3 (b) If veteran, name war: W.W. #1

3 (c) Social Security Account No. 213-01-0399

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: Mary Da Pozzo

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27th 1892

8. AGE: Years: 54 | Months: 8 | Days: 4 | If less than one day: hr. min.

9. Birthplace: Italy
(Town, county, and state)

10. Usual Occupation: Machinist

11. Industry or business: Crown Cork & Seal Co

FATHER
12. Name (Unknown) Da Pozzo
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant: Leo Joseph Da Pozzo
(b) Address: 3030 Boston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/47 (month) (day) (year)
(c) Cemetery or crematory: U.S. National
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 217 St. Paul St.

19 (a) FEB 3 (Date rec'd by registrar) (b) 1947

Filed for Witness

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31 1947, at 9:15 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Carbon Monoxide Poisoning

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-31-47 at 8:30 A.M.
(b) Where did injury occur? 102 W. Barney St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury Escaping gas

23. Signature: George L. Merrill M.D.
Medical Examiner.
Date signed 1/31/47

VS 191

FEB 3 1947

Huntington Williams

X

G48170

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 92B

G48170 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 514 Division St
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1422 Argyle Ave.
(If no street give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Perry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3-10-1897

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 49 | 10 | 20 | hr. min. |

9. Birthplace Jonesboro N. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Stephen Perry
13. Birthplace N.C.

MOTHER
14. Maiden Name Millie Malone
15. Birthplace N.C.

16 (a) Informant Nellie Kelley
(b) Address 310 Allen St. Bluefield W. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-3-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore Md

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania ave

19 (a) (Date received by registrar) FEB 3 1947 (b) Huntington Williams M.D.

VS 181

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 1947, at 1 P M

21. I certify that I took charge of the remains described above, held an Insp. w. Inquest thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic valvulitis (mitral)
Chronic myocardial degeneration
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wheeler, M.D.
Medical Examiner.
Date signed 1-30-47

G48171

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

Registered No. G48171

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument St.
(c) Hospital or institution: Sinai Hospt 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7yr

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Veteran City
2141 Brookfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Max PLAUT

3 (b) If veteran, name war —
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widower |

6 (b) Name of husband or wife Marianne
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | | | hr. min. |

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Jakob
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Hosp. Records
(b) Address

17 (a) Burial (b) Date thereof 2-3-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pt Pl Pet
Location Park Lawn Sta
18 (a) Funeral director Jack Lewis Inc
(b) Address 448 E. Balto St

FEB 3 - 1947 (b) Huntington Williams, Registrar
(Date rec'd by Registrar)

V S 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb 2 1947, at 10 A. M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1947, to Feb 2 1947, and that I last saw him alive on Feb 2 1947.

| Immediate cause of death Pulm. Edema | Duration |
|---|---|
| Due to Art. Sclerosis | |
| Due to Myocard. fibrosis + Cor Pulm. | |
| Other Conditions Hypertrophy | |

Con Carcinomatosis Lung ?
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23.** Signature Leo Rosenbaum M.D.
Address Sinai Hosp. Date signed Feb 3 1947 (M. D.)

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48172

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

137a

Registered No. G48172

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution:
Sinai Hospital, Balt. Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2001 E Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** David Levin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years: 71 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Chaim
13. Birthplace Russia

MOTHER
14. Maiden Name Hannah
15. Birthplace Russia

16 (a) Informant Next Kinsman
(b) Address

17 (a) Burial (b) Date thereof 2-3-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Son
(b) Address 1439 E. Baltimore St.

19 (a) FEB 3 - 1947 (b) Washington Williamsport
(Date rec'd by registrar)

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 3 1947, at 3:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/26 1946 to 2/3 1947, and that I last saw him alive on 2/3 1947.

| | Duration |
|---|---|
| Immediate cause of death Pneumonia, Lobar | |
| Due to Toxemia of Uremia | |
| Due to Bronchopneumonia, Staphylococcic | |
| Other Conditions Pyelonephritis, Chronic, Hypertrophy, Prostatic | |

(Include pregnancy within 3 months of death)

Date of operation 1/3/47

Major findings of operation: None

of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold M. Jaffe M. D.
Address Sinai Hospital Balt. Md. Date signed 2/3/47

G48173

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G48173 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4117 Fairview Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4117 Fairview
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK SILVERMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife: Lillian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): a 1896

8. AGE: Years 51 | Months | Days | If less than one day hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Grocery Store

11. Industry or business

FATHER
12. Name: Jacob
13. Birthplace: Russia

MOTHER
14. Maiden Name: Not Known
15. Birthplace: Russia

16 (a) Informant: Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-3-47 (month) (day) (year)
(c) Cemetery or crematory: Beth Jacob
Location: Windsor Mill Rd.

18 (a) Funeral director: Jack Levin Inc
(b) Address: 1439 E Baltimore

19 (a) FEB 3 - 1947 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/1/47 19 , at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Vascular Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: John R. Ward M.D.
Medical Examiner.
Date signed 2/1/47

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48174

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 467

G48174

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 704 Mad. Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Same
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 704 Mad. Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Milton Green

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-8759

4. Sex M. | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-27-91

8. AGE: Years 56 | Months — | Days 4 | If less than one day hr. min.

9. Birthplace Anne Arundel Co, Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Nicholas Green
13. Birthplace Md.

MOTHER 14. Maiden Name Annie Waters
15. Birthplace Md.

16 (a) Informant James Green
(b) Address 704 Mad. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-3-47 (month) (day) (year)

(c) Cemetery or crematory Hanover, Md.
Location Hanover, Maryland

18 (a) Funeral director Charles L. Law
(b) Address 602 Madison Ave.

(a) (b)
FEB 3 1947 Huntington Williamsport, Md.
VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan 31 1947, at 1 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 29 1947 to Jan 31 1947.
and that I last saw h[illegible] alive on Jan 31 1947.

In addition to cause of death

Due to Pulmonary Tuberculosis — Duration 6 Mos.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature [signature]
Address 737 [illegible] Date signed 2/3/47 M. D.

G48175 BC# 269353

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

Registered No. G48175

Every item of information should be carefully supplied. The write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Eve correct age is especially important. Physicians: please writ

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 709 Lexington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Leroy Belton Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | Negro | child |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-31-47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 1 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Leroy Smith

13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden Name Anne Cross

15. Birthplace Berryville, Va

16 (a) Informant Anne Smith

(b) Address 709 Lexin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-3-47 (month) (day) (year)

(c) Cemetery or crematory Ft. Auburn Cem.

Location Baltimore, Md.

18 (a) Funeral director Charles R. Law

(b) Address 802 Madison Avenue

19 (a) (b)

FEB 3 - 1947

Huntington, W. Va.

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 2-1 1947, at 4:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-31 1947, to 2-1 1947, and that I last saw him alive on 2-1 1947

| Immediate cause of death | Duration |
|---|---|
| Prematurity | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julius S. White M. D.

Address 1802 Penna Ave Date signed 2-3-47

G48176

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 126

Registered No. G48176

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5½ hours
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore #14
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3114 Orlando Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph W. Eliff

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | married |

6 (b) Name of husband or wife Mabel R Eliff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-1-1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 0 | 01 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Thomas Eliff
13. Birthplace Maryland

MOTHER
14. Maiden Name Edna Norris
15. Birthplace Maryland

16 (a) Informant Mrs. Mabel R. Eliff
(b) Address 3114 Orlando Ave

17 (a) Burial (b) Date thereof 2/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto

18 (a) Funeral director Leonard Ruck
(b) Address 5305 Harford Rd

19 (a) (Date received by Registrar) FEB 3 1947 Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 2 1947, at 12:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1-47 19__ to 2-2 1947, and that I last saw h__ alive on Feb 2 1947.

Immediate cause of death Shock — Duration

Due to

Due to

Other Conditions Cardiovascular disease
(Include pregnancy within 3 months of death)

Date of operation February 1, 1947

Major findings of operation: Cholelithiasis

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward P. Smith, M.D.
M. D.
Address Mercy Hospital Date signed 2-2-47

Interior Williams, MD

M. D. R. 1248-0

# HEALTH DEPARTMENT—CITY OF BALTIMORE

G48177

## CERTIFICATE OF DEATH × 61

G48177

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 5410 Gerland Ave. Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. 7 ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Elizabeth Ellingson

(a) Residence: No. 1908 Rosedale ave Balto St. Md Ward. Baltimore Co.

(Usual place of abode) (If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. Color or Race | 5. Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| F | W | Widow |

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John Ellingson

6. DATE OF BIRTH (month, day, year) 7/4/1875

| 7. AGE Years | Months | Days 28 | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|
| 71 | 6 | 29 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. At Home

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore Co Md

FATHER

13. NAME John Bauer

14. BIRTHPLACE (city or town) (State or country) Balto. Md

MOTHER

15. MAIDEN NAME Margaret —

16. BIRTHPLACE (city or town) (State or country) —

17. INFORMANT Mrs Henry W Hartman

(Address) 5410 Gerland Ave

18. BURIAL, ~~CREMATION, OR REMOVAL~~

Place Holy Redeemer Date 2/5 47

19. UNDERTAKER Langahn Funeral Home

(Address) 7460 Belair Rd

20. FILED FEB 3 - 1947, 19 ... Huntington Williams Registrar

### MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Feb 2, 1947

22. I HEREBY CERTIFY, That I attended deceased from July 1, 1946 to Feb 2, 1947

last saw h... alive on Feb 2, 1947 Death is said to have occurred on the date stated above, at 6 A. m.

The principal cause of death and related causes of importance were as follows:

Coronary Thrombosis — Date of onset Sudden

Other contributory causes of importance:

Arterio-Sclerotic-Cardio vascular disease
Diabetes Mellitus

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? No If so, specify ...

(Signed) Geo. M. Ogumgundyen M. D.

(Address) Balto 6 Md. 94a

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48178

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 107

Registered No. G48178

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 931 S. Linwood Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 931 S Linwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leroy Junior Deppish

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 18 1927

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 19 | 1 | 13 | hr. min. |

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Frank L. Deppish
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Ada Long
15. Birthplace Baltimore County

16 (a) Informant Frank L. Deppish
(b) Address 931 S. Linwood Ave

17 (a) Burial (b) Date thereof 2-4-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Eastern Ave Rd

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.

19 FEB 3 1947 (b) Huntington Williams Md
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1 1947 at 4:25 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 30 1947 to Feb 1 1947 and that I last saw him alive on Feb 1 1947

Immediate cause of death Bronchio-Pneumonia 2 days

Due to Pseudohypertrophic

Due to Muscular Paralysis.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L B Stevens M.D.
Address 3908 Eastern Date signed 2/3/47

VS 3

G48179

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

107

G48179 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address Rayner Ave. & Dukeland St.

(c) Hospital or institution: West Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md. (b) County

(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)

(d) Street No. 829 S. Kenwood ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Mrs. Mary Nawrocki

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Walter Nawrocki

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Nov. 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 23 | | hr. min. |

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name Dupe

FATHER 13. Birthplace Poland

MOTHER 14. Maiden Name ?

MOTHER 15. Birthplace Poland

16 (a) Informant Anthony J. Nawrocki

(b) Address 829 S. Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 / 5 / 47 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus Cemetery

Location Dundalk Ave

18 (a) Funeral director John J. Dudy

(b) Address 2029 Hudson St. Baltimore, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 3 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 2, 1947 at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 31, 1947 to Feb. 2, 1947 and that I last saw her alive on Feb. 2, 1947

| Immediate cause of death | Duration |
|---|---|
| Cardiorespiratory failure | |
| Due to Pneumonia | |
| Due to Cardiac decompensation & Pulmonary edema | over |
| Other Conditions Arteriosclerosis | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Leon Toby M.D.

Address West Balto Gen. Hosp. Date signed 2/2/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48180

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G48180 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1125 Linden Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Joseph Rosenberg

3 (b) If veteran, name war: W.W. I
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M. | W | M. |

6 (b) Name of husband or wife: Gertrude Cantor
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 7/19/1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 6 | 12 | hr. min. |

9. Birthplace: Balto.
(Town, county, and state)
10. Usual Occupation: Grocer
11. Industry or business:

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant: Family
(b) Address: 1125 Linden Ave.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 2-4-47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Pk.
Location: Fredrick Ave.

18 (a) Funeral director: L. H. Hamburger
(b) Address: 1307 E. Fayette St.

19 (a) (Registered by registrar) (b) Huntington for Williams Registrar

FEB 3 - 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/1 1947 4:10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1 1946 to 2/1 1947.
and that I last saw h[illegible] alive on 2/1 1947.

| Immediate cause of death | Duration |
|---|---|
| Bleeding Pulmonary Ulcer | 2 hrs |
| Due to Acute Dilatation of the Heart | 2 hrs |
| Due to Chronic Myocarditis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Hugh H. Sadler
Address: 2326 E. Baltimore St. Date signed 2/3/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48181

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

95c

G48181 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Linden & Madison St.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2204 Garrison Blvd.
(If rural give location)
(e) Citizen of foreign country? [illegible] (Alien or No)
If yes, name country

**3 (a) FULL NAME** Dr. William A. Rea (Dr. William Acheson Rea)

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| None | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed or divorced |
|---|---|---|
| M | Wh. | Married |

6 (b) Name of husband or wife: Ruby M. Rea
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 11 | 9 | hr. min. |

9. Birthplace Wash. Co. Pa. (Town, county, and state)
10. Usual Occupation Dentist
11. Industry or business

FATHER
12. Name Wm. Mason Rea
13. Birthplace Wash Co. Pa.

MOTHER
14. Maiden Name Margaret Jane Acheson
15. Birthplace Wash. Co. Pa.

16 (a) Informant Mrs. Ruby M. Rea
(b) Address 2204 Garrison Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 4, 1947 (month) (day) (year)
(c) Cemetery or crematory Lorraine Mausoleum
Location Balto. Co. Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Ave.

19 (a) (Date rec'd by registrar) (b) (Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1 Feb. 1947, at 1.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 15 Jan. 1947, to 1 Feb. 1947, and that I last saw him alive on 1 Feb. 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardiac decompensation | |
| Due to | |
| Due to | |
| Other Conditions Chronic parenchymatous nephritis, possible carcinomatosis | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. T. McDougan M. D.
Address Md. Gen. Hosp. Date signed Feb. 1, 47

FEB 1947

Huntington Hollins

VS 130

X

G48182

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1226

Registered No. G48182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairfield Ave
(c) Hospital or institution: Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 01

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Sparrows Point
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 C Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** William P. Hill, Jr.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | no |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | S |

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 25 Feb. 1942

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 4 | 11 | 6 | hr. min. |

9. Birthplace Sparrow's Point, Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

**FATHER**
12. Name Wm. P. Hill, Sr.
13. Birthplace Delaware

**MOTHER**
14. Maiden Name Bertha Brittingham
15. Birthplace Delaware

16 (a) Informant Wm. P. Hill, Sr.
(b) Address 806 C Ave, Sparrows Pt, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/47 (month) (day) (year)
(c) Cemetery or crematory
Location Rehoboth, Del.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Wilmington, Del.
(Date rec'd by registrar) (Registrar)

FEB 5 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Feb 1947, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 31 Jan 1947 to 1 Feb 1947, and that I last saw him alive on 1 Feb 1947

| Immediate cause of death | Duration |
|---|---|
| Cardio-Vascular Failure | 24 hrs |
| Due to Intestinal Obstruction | |
| Due to Volvulus | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation 1/30/47
Major findings of operation: Volvulus (18" of ileum resected)
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nicholas J. Kohlenberger M. D.
Address The Church Home & Hosp. Date signed 1 Feb 1947

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48183

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 47

R G48183

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3414 Holmes Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3414 Holmes Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: EUGENE B. McCURDY

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 214-18-5068

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Annie B. McCurdy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1871

8. AGE: Years 75 | Months 9 | Days 14 | If less than one day hr. min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation Motion Picture Exec.

11. Industry or business Eureka Amusement Co.

FATHER
12. Name -
13. Birthplace -

MOTHER
14. Maiden Name Amanda J. Severe
15. Birthplace -

16 (a) Informant Mrs. Helen E. Worman
(b) Address 829 Mt. Holly St. 29

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

FEB 3 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31, 1947, at 8:52 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-24 1946 to 1-31 1947 and that I last saw h. alive on 1/31 1947.

Immediate cause of death: Acute Cardiac Failure — Duration: 12a
Due to: Primary Arteriosclerosis — left lung
Due to: Congenital Arteriosclerotic Cardiovascular Disease — yrs
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Joseph L. Faulkner, M.D.
Address 67 Winchester Blvd Date signed 2/4/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48184
AB-91614

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 1937

G48184
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs- 6mos. 16days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DEASCEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. [illegible] W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Richard C. Woolf

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Widower |

6 (b) Name of husband or wife: Minnie (D.) B. (nee Taylor)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17- 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 2 | 14 | hr. min. |

9. Birthplace Maryland (Baltimore)
(Town, county, and state)
10. Usual Occupation --
11. Industry or business --

FATHER
12. Name Henry P. Woolf (D
13. Birthplace Maryland

MOTHER
14. Maiden Name Caroline Marine (D
15. Birthplace St. Augustine-Florida

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 2/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) FEB 3 1947 (b) [illegible] Registrar
(Date received by Local Registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 1 1947 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15- 1945 to 2-1- 1947, and that I last saw h[illegible] alive on 2-1- 1947

| Immediate cause of death | Duration |
|---|---|
| Congestive Ht. Failure. | |
| Due to Arteriosclerotic C-V Disease | |
| Due to | |
| Other Conditions Auricular fibrillation | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert R. Farber M. D.
Address Balto. City Hosps Date signed 2-1-47

X

G48185

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G48185

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution: Mercy Memorial Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 101 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2938 St Paul St. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

**3 (a) FULL NAME** RAYMOND THOMAS ROSS

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Pemberton Emmette Ross
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) APRIL 25, 1902
8. AGE: Years 44 | Months 9 | Days 6 | If less than one day — hr. — min.
9. Birthplace California (Town, county, and state)
10. Usual Occupation Clerical
11. Industry or business Bethlehem Steel

FATHER
12. Name A. T. Ross
13. Birthplace California

MOTHER
14. Maiden Name Fay Treffery
15. Birthplace --

16 (a) Informant Mrs Pauline Ross
(b) Address 2938 St Paul Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 3, 1947 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) ..... (b) ..... Registrar
(Date received by registrar) FEB 3 - 1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/31 1947, at 2.40 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 10/22 1946 to 1/31 1947, and that I last saw h. alive on 1/31 1947.

| | Duration |
|---|---|
| Immediate cause of death: Aneurysm of ventricle | 12 days |
| Due to: Myocardial degeneration | 101 days |
| Due to: Coronary Thrombosis | 102 days |
| Other Conditions: | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address Mercy Mem Hosp Date signed 1/31/47

X

G48186

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48186

Registered No. 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Milbrook & Caton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9 Rognell Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs Charles A. Smith

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | no |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Barbara Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 4 | 22 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Joseph Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Mary M. Murk
15. Birthplace Germany

16 (a) Informant Mrs. Barbara A. Smith, wife
(b) Address 9 Rognel Ave., Catonsville

17 (a) Burial (b) Date thereof 2/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

FEB 3 1947 (b) [illegible]
(Date rec'd by Registrar) Registrar

VS 130

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 1947; at 9.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from January 9 1947 to 2-1 1947, and that I last saw him alive on 2-1 1947.

| | Duration |
|---|---|
| Immediate cause of death Respiratory failure | |
| Due to Pneumonia, | |
| Due to Hypostasis | |
| Other Conditions Fract. hip, decubitus ulcers, Gen. debility | |

(Include pregnancy within three months of death)

Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Acc.
(b) Date of occurrence 1-9-47 at 1 M
(c) Where did injury occur? 9 Rognell Ave.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Fell at home: slipped on floor

23. Signature Wm. A. Langley, M.D.
Address 6 St. Agnes Hosp. Date signed 2-1-47

Birth Certificate
G48187
D-69244

BALTIMORE CITY HEALTH DEPARTMENT X
# CERTIFICATE OF DEATH 1579

G48187
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Walkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Anne Arundel County
(If outside city or town limits, write RURAL and give town)
(d) Street No. Annapolis Blvd. & F. Dr. Box 438 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Kenneth Faulstich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-27-47

8. AGE: Years | Months | Days: 7 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Martin

13. Birthplace Md.

MOTHER 14. Maiden Name Ruth Wolff

15. Birthplace Md.

16 (a) Informant Hospital Records

(b) Address Walkens & Caton Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2-3-47 (month) (day) (year)

(c) Cemetery or crematory Moreland PK

Location Balto. Co. Md.

18 (a) Funeral director Bernard J. Reed

(b) Address 5305 Harford Rd.

19 (a) (Signature of registrar) (b) Huntington Williams Registrar

FEB 3 - 1947

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 2-3 1947 at 4:15 PM

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2-2 1947 to 2-3 1947 and that I last saw him alive on 2-3 1947

Immediate cause of death: Cardiac failure
Interstitial Pneumonitis
Atelectasis at Lepratelia
Due to Otitis Media
Death from Mastoiditis
Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 2/2/47
Major findings of operation: Mastoidectomy
of Right Side
of autopsy

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. H. Mentz M.D.
Address St Agnes Date signed 2/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48188

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH 1937

Registered No. G48188

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 819 W. Fayette st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Sprinkel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: late Gertrude M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1893

8. AGE: Years 53 | Months 6 | Days 9 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER 12. Name Enos Sprinkel

13. Birthplace Va.

MOTHER 14. Maiden Name Ida J. Fry

15. Birthplace Va.

16 (a) Informant Mrs Oscar O. Burr

(b) Address 1004 W Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location 3801 Frederick Ave

18 (a) Funeral director John F. Enos & Son

(b) Address 904-03 Gilmor St

FEB 3 - 1947 (b)
(Date rec'd by registrar) Registrar

Huntington Williams M.D.

VS 151

### MEDICAL CERTIFICATION

20. DATE OF DEATH 2/1/1947, at 12-25 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular Disease.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis MD per H. H. Merrill M.D.
Medical Examiner.
Date signed 2-3-47

G48189

BALTIMORE CITY HEALTH DEPARTMENT X

# CERTIFICATE OF DEATH ✓ 937

G48189
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1614 Division St
(c) Hospital or institution:
PROVIDENT Hospital ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 Oak Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** James Edward McCain

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Negro | Married |

6 (b) Name of husband or wife Celia McCain
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) 8-15-1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 5 | 14 | hr. min. |

9. Birthplace Halifax County, Virginia
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name James McCain
13. Birthplace Ridgeville, North Carolina

MOTHER
14. Maiden Name Isabella Pleasant
15. Birthplace Halifax, Virginia

16 (a) Informant Angeline James
(b) Address 908 NewHampshire Ave D.C

17 (a) Burial (b) Date thereof 2/3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Ave

19 (a) FEB 3 1947 (b) Huntington Williams, M.D.
(Filed by registrar) Registrar

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Jan. 29 1947, at 8:30 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan. 28 1947 to Jan 29 1947, and that I last saw him alive on Jan 29 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Thrombosis | 3 days |
| Due to Hypertensive C.V. Disease with Arteriosclerosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Encephalomalacia, Arteriosclerosis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

**23.** Signature Thomas Brooks
Address 757 Brantly Ave Date signed 2/3/47

LAURA Boyd

G48190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √ 93D

G48190 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1511 Vine Baltimore
(c) Hospital or institution: No
(d) Length of stay in hospital or inst. (yrs., mos., or days) No
(e) Length of stay in Baltimore (yrs., mos., or days) 5

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 Vine St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lura Boyd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fem

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Austin Boyd

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 6, 1880

8. AGE: Years 66 | Months 11 | Days 24 | If less than one day hr. min

9. Birthplace Cross Hill S Carolina (Town, county, and state)

10. Usual Occupation Domestic.

11. Industry or business

FATHER 12. Name S. Caroline

13. Birthplace

MOTHER 14. Maiden Name Mary Leak

15. Birthplace S. Carolina

16 (a) Informant Elijah Leak.

(b) Address 24 N. Vincent St

17 (a) Interment Shipped (Burial, cremation, or removal) (b) Date thereof Feb 3, 1947 (month) (day) (year)

(c) Cemetery or crematory Cross Hill S.C.

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 222 N. Schroeder St

19 (a) FEB 3 - 1947 (Date rec'd by registrar) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 30 1947 at 3.10 P

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30 1947 to Jan 30 1947 and that I last saw her alive on Jan 30 1947

Immediate cause of death Coronary Thrombosis — Duration 6 min

Due to

Due to

Other Conditions

(Include pregnancy within three months of death)

Date of operation No

Major findings of operation: N

of autopsy: No

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. E. Lusk M. D.

Address North Ave & Dawson Date signed Jan 30

VS 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48191 — 12# G26889 — BALTIMORE CITY HEALTH DEPARTMENT — CERTIFICATE OF DEATH — 95a — Registered No. G48191

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 25
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2901 Spellman Road (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

**3 (a) FULL NAME** Earl Tony James.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Black | |

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 6-19-45

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 1 | 7 18 | 11 | ..... hr. ..... min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name Walter James
13. Birthplace Va.

MOTHER
14. Maiden Name Irene Wenk
15. Birthplace md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 3, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location.....

18 (a) Funeral director Wm. Kater P. Williams
(b) Address 322 N. Edmondson Ave.

19 FEB 3 1947 (b) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 30 1947, at 10. P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 30 1947 to Jan. 30 1947, and that I last saw him alive on Jan. 30 1947.

| Immediate cause of death | Duration |
|---|---|
| Ventricular fibrillation | |
| Ventricular " " | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Herbert Gunson M. D.
Address Johns Hopkins Hosp. Date signed 1-31-47

VS 150

Trans. C48192

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 926

C48192

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St.
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 520 E 38th St Balt 18
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Catherine M Brandt.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widowed |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22-1880

| 8. AGE: Years | Months | Days | If less than one day: hr. | min. |
|---|---|---|---|---|
| 66 | 9 | 9 | | |

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Paul F. Brandt

13. Birthplace Washington D.C.

MOTHER 14. Maiden Name C.M. Faulhaber

15. Birthplace Washington D.C.

16 (a) Informant Miss Ruth Brandt

(b) Address 520 E. 38th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/47 (month) (day) (year)

(c) Cemetery or crematory St. Mary's Cem

Location Washington, D.C.

18 (a) Funeral director Wiedefeld & Son

(b) Address Greenmount Ave & 22nd St.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 3 - 1947 Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 31st 1947, at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 9 1947, to Jan 31 1947, and that I last saw deceased alive on Jan 31 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardio-Respiratory Failure. | |
| Due to Cardiac decompensation | |
| Due to with aortic & mitral valvular | |
| Other Conditions Insufficiency | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry F. Wilson Jr. M. D.

Address St. Joseph's Hosp Date signed 1/31/47

X

G48193

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G48193 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 820 Union Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 820 Union Ave.
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME Kuni E. Kroner.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife George Kroner.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1870

8. AGE: Years 76 | Months 10 | Days - | If less than one day hr. min.

9. Birthplace Germany.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Conrad Kriener
13. Birthplace Germany.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown.

16 (a) Informant Conrad H. Kroner.
(b) Address 2011 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 4/47 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director Chenowith & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) FEB 3 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1, 1947 at 4:35A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1946 to Feb 1 1947 and that I last saw h[illegible] alive on June 31 1947

Immediate cause of death
Cerebral Thrombosis, left — Duration 5 days
Due to Arteriosclerosis, hypertension — 10 yrs
Cardio Vascular Disease
Due to Endocarditis, Chronic — 10 yrs
Other Conditions Pulmonary — 3 days
Edema, right
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John P. Ulrich, Jr M.D.
Address 1226 Wash. Blvd Date signed 2/1/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G4819 BC# G64617 BALTIMORE CITY HEALTH DEPARTMENT G48194
CERTIFICATE OF DEATH 159 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution:
University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4904 Litchfield Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Adams

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 2 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 2 | 6/0 | hr. min. |

9. Birthplace University Hospital, Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph L. Adams.
13. Birthplace Md.

MOTHER
14. Maiden Name Evelyn Hand.
15. Birthplace England.

16 (a) Informant Joseph L. Adams.
(b) Address 4904 Litchfield Ave.

17 (a) Burial (b) Date thereof Feb 4 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Chenoweth & Damarson.
(b) Address 2615-17 Chestnut Ave.

19 (a) FEB 8 1947 (Date received by registrar) Lovington Williams, M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb. 2 1947, at 8 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24 1947 to Feb. 2 1947, and that I last saw her alive on Feb. 2 1947.

| Immediate cause of death | Duration |
|---|---|
| Premature birth | |
| Due to Premature Labor | |
| Due to — | |
| Other Conditions Poor nutrition & general development. (Include pregnancy within 3 months of death) | |

Date of operation none
Major findings of operation: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E. McCurdy M. D.
Address University Hospital Date signed 2/3/47

X

G48195 BC# G66170

BALTIMORE CITY HEALTH DEPARTMENT G48195
Registered No.

# CERTIFICATE OF DEATH 119a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNION MEMORIAL HOSPITAL 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 10
(e) Length of stay in Baltimore (yrs., mos., or days) 1 month, 10 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MARYLAND (b) County
(c) City or town BALTIMORE 11
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 W 37 St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** BABY BOY FULTON

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: WH
6 (a) Single, married, widowed, or divorced: SINGLE
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 23, 1946
8. AGE: Years | Months: 1 | Days: 10 | If less than one day: hr. min.
9. Birthplace: BALTIMORE MD (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name: ROBERT THOMAS FULTON
13. Birthplace: BALTIMORE

MOTHER
14. Maiden Name: INIS TOLLIVER
15. Birthplace: FREE BORN KENTUCKY

16 (a) Informant: HOSPITAL RECORDS
(b) Address

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Feb. 2 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Manga
Location Hampden.

18 (a) Funeral director L. Hemsworth & Company
(b) Address 3615-17 Chestnut Ave
19 (c) 1947 Registrar
(Date received by registrar)

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb 2 1947; at 2 15 M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1947 to Feb 2 1947, and that I last saw him alive on Feb 1 1947.

| | Duration |
|---|---|
| Immediate cause of death: PNEUMONIA, Rt & Lt Lobar | 1 day |
| Due to | |
| Due to | |
| Other Conditions: Diarrhea Erythema Congenital Lues lip & cleft palate, left (Include pregnancy within 3 months of death) | 10 days |
| Date of operation | PHYSICIAN |
| Major findings of operation | Underline the cause to which death should be charged statistically. |
| of autopsy: | |

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Edwin B Chamberlain M. D.
Address: Union Memorial Hosp Date signed: 2/2/47

334 Calvert St

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48196 BALTIMORE CITY HEALTH DEPARTMENT G48196

# CERTIFICATE OF DEATH

Registered No. 170 C

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore HAMPDEN
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1012- Union Ave. ~~Woodberry~~
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** FRANCIS J. O' LEARY

3 (b) If veteran, name war: W. W. II

3 (c) Social Security Account No. 219-22-4840

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married. |

6 (b) Name of husband or wife Florence M. O'Leary
6 (c) If alive, give age 19 years

7. Birth date of deceased (mo., day, yr.) May 2, 1927

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 19 | 9 | - | hr. min. |

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation Apprentice machinist
11. Industry or business Balmar Corp

FATHER
12. Name Charles O'Leary Sr.
13. Birthplace Md.

MOTHER
14. Maiden Name Sadie Cashman
15. Birthplace Md

16 (a) Informant Charles O'Leary Sr.
(b) Address 1012 Union Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 6 1947 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Windsor Mill Rd.

18 (a) Funeral director Chenoweth & Donovan.
(b) Address 3615 - [illegible]

19 (a) 1947 (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 2, 1947, at 10.35 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Ruptured Aorta, traumatic.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-2-47 at 8.30 p. M. a.a.hw.
(b) Where did injury occur? near Mountain Rd. Lipin's corner
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Auto, ~~Auto~~ collision

23. Signature Howard J. Weldon M.D.
Medical Examiner.
Date signed 2-3-47

VS 151

G48197

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48197 Registered No. 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Balto Gen'l Hosp'l
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 9

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1232 Ridgely Pl (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Thomasina Bockmyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W. | M. |

6 (b) Name of husband or wife Charles.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/8/1903

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 43 | 8 | 13 | hr. min. |

9. Birthplace Wash. D.C. (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

**FATHER**
12. Name Frank M. Metzler
13. Birthplace Baltimore, Md

**MOTHER**
14. Maiden Name Mary Christian
15. Birthplace Baltimore, Md

16 (a) Informant Mary Johnson
(b) Address 1745 Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 4, 1947 (month) (day) (year)
(c) Cemetery or crematory Westerns
Location Baltimore, Md

18 (a) Funeral director Howard D. Covington
(b) Address 21 W. Lexington St Baltimore, Md

19 (a) (b) Registrar

FEB 3 1947

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 2-1 1947 at 3:25 PM

**21.** I certify that death occurred on the date above stated; that I attended deceased from 1/17 1947 to 2/1 1947 and that I last saw h[illegible] alive on 2/1 1947.

Immediate cause of death: Pulmonary infarction
Left-lower lobe

| Duration |
|---|
| |
| |
| |
| |

Due to Pulmonary embolus

Due to

Other Conditions 2nd & 3rd Lumbar.
50% of Body surface
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Above.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide? Accident
(b) Date of occurrence 1/17/47 at 11:45 AM
(c) Where did injury occur? Balto. Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home. While at work? No.
(Specify type of place)
(e) Means of injury? Fall on floor

**23.** Signature Harry F. Greenwell, M. D.
Address 1213 Light St Date signed 2/4/47

For S. R. Davis, by Howard J. Mercer, M. D.

VS 150

G48198 BALTIMORE CITY HEALTH DEPARTMENT G48198 Registered No.

# CERTIFICATE OF DEATH V186a

TN. 107309

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 Poplar Grove St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Pons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28/1872

8. AGE: Years 74 | Months 4 | Days 3 4 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Micheal Silk ( D
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Tarell ( D
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 5 47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 41st Block Edmondson Ave

18 (a) Funeral director Robert L Burooks
(b) Address 1334 Harlem Huntington Ave Baltimore, Md

(a) FEB 3 1947 (b) (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH Feb. (2nd) 1947 19 47, at 7.00 M

21. I certify that death occurred on the date above stated that I attended deceased from Jan. 1st/ 19 47 to Feb. (2nd) 19 47 and that I last saw her alive on Feb (2nd) 19 47

| | Duration |
|---|---|
| Immediate cause of death Left cerebral Hemorrhage | |
| Due to Generalized arteriosclerosis | |
| Due to | |
| Other Conditions Bronchopneumonia, Fracture neck of right femur | |

(Include pregnancy within 3 months of death)

Date of operation 1/31/47

Major findings of operation: Fracture neck of right femur

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide acc.
(b) Date of occurrence Aug. 24, 1946 at 2 M
(c) Where did injury occur? 1804 Poplar Grove (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Slipped & fell to floor,

23. Signature H F Bakes

Address Baltimore City Hosp. Date signed 2/7/47

VS 150 To be Approved by the Medical Examiner Howard J. Mackey, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48199

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V 92 C

G48199 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1004 N. Eden St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 N. Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Eulaw Garland

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6 1889

8. AGE: Years 57 | Months 4 | Days 25 | If less than one day: hr. min.

9. Birthplace Lunenburg Co Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Sylvanus Garland
13. Birthplace Va.

MOTHER 14. Maiden Name Rebecca Atkins
15. Birthplace Va.

16 (a) Informant Lenora Parker
(b) Address 241 Broad St. Hammond Ind

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 3 1947 (month) (day) (year)
(c) Cemetery or crematory
Location Lunenburg Co Va.

18 (a) Funeral director Mrs. Robt. A. Edwards Dft
(b) Address 1297 W. Carlyle St. Huntington Williamson W Va

19 1947 (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1 1947 at 2:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1947 to Feb 1 1947, and that I last saw h[illegible] alive on Feb 1 1947.

| Immediate cause of death | Duration |
|---|---|
| Acute heart failure c | |
| Thrombo-embolic disease | 1 wk |
| Due to Rheumatic endocarditis | ? |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. J. Pafford M. D.
Address 1422 E. Pleasant St Date signed

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48200

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 148a

Registered No. G48200

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1621-E Monument Ave
(c) Hospital or institution: Residence 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1621-E Monument Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Annie Melvina Newman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Wm. E. Newman

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Aug. 10th 1913

8. AGE: Years 33 | Months 5 | Days 21 | If less than one day 7 hr. 10 min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER — 12. Name Wilmer Denton

13. Birthplace Balto. Md.

MOTHER — 14. Maiden Name Annie Hunt

15. Birthplace Balto. Md.

16 (a) Informant Wm. E. Newman

(b) Address 1621-E Monument Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/47 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Pk

Location Md

18 (a) Funeral director Meg. B. Gibson

(b) Address 1383 Pressman St

19 FEB 3 - 1947 (Date rec'd by Local Reg.) Huntington Williams, Md. Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Jan. 31 1947 at 7:30 A.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan. 1946 to Jan. 31 1947 and that I last saw h[illegible] alive on Jan. 27 1947.

Immediate cause of death Carcinoma Cervix — Duration 1 yr-Mos

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature D. M.S.K. Reesby

Address 756-Dolphin St. Date signed 2/1/47 (M. D.)

VS 150

X

G48201

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G48201

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA 15
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2512 Ellamont
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Thomas McCafferty

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | |

6 (b) Name of husband or wife Delia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | | | hr. min. |

9. Birthplace Ireland (City, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Duncan McCafferty
13. Birthplace Ireland

MOTHER 14. Maiden Name Sydney Nalen
15. Birthplace Ireland

16 (a) Informant Mrs Thos McCafferty
(b) Address 2512 Ellamont St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/47 (month) (day) (year)

(c) Cemetery or crematory Cash Hale
Location Baltimore, Md

18 (a) Funeral director George A. Farley
(b) Address Eutaw & Fayette

19 (Filed by registrar) Huntington Hills Cemetery

FEB 3 - 1947

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/1/47 19..., at 9:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Dawson M.D.
Medical Examiner.
Date signed 2/1/47

G48202

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 94a

Registered No. G48202

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1136 Madison St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

**3 (a) FULL NAME** Edward Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1898

8. AGE: Years 48 | Months 8 | Days 19 | If less than one day .....hr. .....min.

9. Birthplace Petersburg.
(Town, county and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER — 12. Name Edward Smith
13. Birthplace Petersburg Va.

MOTHER — 14. Maiden Name Ella
15. Birthplace Petersburg Va.

16 (a) Informant Connie Jones
(b) Address 410 Brown Ave Petersburg Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/47 (month) (day) (year)

(c) Cemetery or crematory Baltimore National
Location Elroy A. Wilson

18 (a) Funeral director.....
(b) Address 1000 Booth Street

19 (a) 2/3/47 (Date rec'd by registrar) (Huntington Williamsville, Md.)

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1947, at 11:33 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary artery disease
Edema and congestion of lungs
Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 1/29/47

VS 191

X

G48203

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1927

Reg. No. G48203

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 506 E. 36th St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 E. 36th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Susan Jane Blatchley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband: Robert H. Blatchley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 5th 1869

8. AGE: Years 77 | Months 9 | Days 27 | If less than one day hr. min. 26

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: James Barnett
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mary Barnett
15. Birthplace: Md.

16 (a) Informant: Robt. H. Blatchley Jr.
(b) Address: 601 E. 41st St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/4/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~: Parkwood
Location: Parkville Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb 1st 1947 10:30 A.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1947 to Feb 1 1947 and that I last saw h e alive on Jan 30 1947.

Immediate cause of death: Hemiplegia — Duration: Immediate
Due to: Arteriosclerosis generalized
Due to:
Other Conditions: Chr. Myocarditis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23. Signature** Nathaniel McBeth M. D.
Address 1005 E. 23rd St Date signed Feb 2-47

VS 150
FEB 3 - 1947
Huntington Williams, M

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48204 — BALTIMORE CITY HEALTH DEPARTMENT — G48204 Registered No.

# CERTIFICATE OF DEATH

131a

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5405 York Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 5405 York Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** George E. Dilworth

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~ |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of ~~husband~~ or wife Martha T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 4 1863

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 8 | 27 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Grocer
11. Industry or business Own Business

FATHER
12. Name George Dilworth
13. Birthplace York, Md.

MOTHER
14. Maiden Name ?
15. Birthplace Balto Co. Md.

16 (a) Informant Mrs Henry P. Smith
(b) Address 5405 York Rd.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/4/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Methodist
Location Fork Md.

18 (a) Funeral director Williams Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (b) Huntington Williamstown, Md.
(Per ~~S~~'d by registrar) FEB 3 1947

VS 155

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1st 1947, at 7:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1947 to Feb 1 1947 and that I last saw him alive on Feb 1 1947.

| Immediate cause of death | Duration |
|---|---|
| (a) Chron Myocarditis | 1 yr |
| (b) Chron Interstitial Nephritis | 1 yr |
| Due to | |
| Due to | |
| Other Conditions Arterio Sclerosis Gallstones | 1 yr |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? No While at work? (Specify type of place)
(e) Means of injury

23. Signature E. N. Brady M. D.
Address 503 Shenandoa Date signed Feb 3 1947

X

G48205

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X √ 164 c

G48205
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hosp. DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County A. A.
(c) City or town Severn (If outside city or town limits, write RURAL and give town)
(d) Street No. Elm Station (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Maurice Winfred Holley

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. 241-03-9793

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | W |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 6 | 12 | hr. min. |

9. Birthplace Westminister S.C. (Town, county, and state)
10. Usual Occupation Shop Foreman
11. Industry or business Air Brakes & Couplers

FATHER
12. Name John L. Holley
13. Birthplace Westminister, S.C.

MOTHER
14. Maiden Name Green Land
15. Birthplace Seneca, S.C.

16 (a) Informant F. A. Marvin
(b) Address 5812, 2nd St, Arlington, D.C.

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 2/3/47 (month) (day) (year)
(c) Cemetery or crematory Sharon Memorial
Location Charlotte, N.C.

18 (a) Funeral director Wilson & Sons
(b) Address 1347 F St. N.W. Washington, D.C.

19 (a) FEB 3 - 1947 (b)
(Date rec'd by registrar) Registrar

VS 191

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 2, 1947, at 7 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wound of brain
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2/2/47 at 5:10 P. M.
(b) Where did injury occur? Elm Station, Severn R.F.D. Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? NO
(d) Means of injury Firearms

23. Signature Howard J. Wallis M.D.
Medical Examiner.
Date signed 2/3/47

X

G48206 BC# BALTIMORE CITY HEALTH DEPARTMENT X G48206

G67897 CERTIFICATE OF DEATH ✓ 119a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Boyner Ave. & Dukeland
(c) Hospital or institution: W. Balt. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19days
(e) Length of stay in Baltimore (yrs., mos., or days) 19days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Middle River Baltimore #21
(If outside city or town limits, write RURAL and give town)
(d) Street No. 183 Edgewater Apts (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

**3 (a) FULL NAME** Baby Boy Glesser

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15-47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 19 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER 12. Name Philip Glesser

13. Birthplace Penna.

MOTHER 14. Maiden Name Margeret Wagner

15. Birthplace Ohio

16 (a) Informant Philip Glesser.

(b) Address 183 Edgewater Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/3/47 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart. Location Gerrys Hill Rd

18 (a) Funeral director John D Connelly.

(b) Address 412 Eastern Ave. Balto 21, Md

FEB 3 - 1947 (Date rec'd by Registrar) (b) Registrar

Huntington Williams MD

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 2-3-47 at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-16 1947 to 2-3 1947. and that I last saw h[illegible] alive on 2-3 1947.

| Immediate cause of death | Interval between onset and death | Duration |
|---|---|---|
| Asphyxia Neonatorum | | |
| Due to Infectious diarrhea | | |
| Due to | | |
| Other Conditions prematurity | | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Negative

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. J. Trepton

Address W. Balto Gen Hosp Date signed 2-3-47 M. D.

X

G48207

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G48207 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5515 Belair Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5515 Belair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ELIZABETH HERTING

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: WILLIAM F. HERTING

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 7, 1870

8. AGE: Years 76 | Months 10, | Days 25 | If less than one day hr. min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John McNally
13. Birthplace Ireland

MOTHER
14. Maiden Name Henrietta Campaging
15. Birthplace Maryland

16 (a) Informant Mrs. Fidellia Steigerwald
(b) Address 5515 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/47 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK CEMETERY
Location BALTIMORE, MARYLAND

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) (Place of burial, removal, or cremation) (b) Filed FEB 3 1947 (c) Registrar

V5 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1947 to Feb 1 1947, and that I last saw her alive on Feb 1 1947.

| Immediate cause of death | Duration |
|---|---|
| Chronic Myocarditis | 3 yrs. |
| Due to Arteriosclerosis | 20 yrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Haven Lachman, M.D.
Address 4980 Belair Rd Date signed Feb 4 1947

C48208 | BALTIMORE CITY HEALTH DEPARTMENT | Registered No. C48208

# CERTIFICATE OF DEATH 1312

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11yrs-8mos.-20days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 N. Wolfe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Sweeney (CHARLES JOSEPH SWEENEY)

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Cecelia Sweeney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18- 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 2 | 14 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation City of Baltimore
11. Industry or business

FATHER
12. Name Charles Sweeney
13. Birthplace Maryland

MOTHER
14. Maiden Name Honora Galagher
15. Birthplace Ireland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 2/5/47 (Burial, cremation, or removal) (month), (day), (year)
(c) Cemetery or crematory St Peters
Location BALTIMORE, MARYLAND

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 FEB 3 - 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 2- 1947, at AM 10.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-13 1935 to 2-2- 1947, and that I last saw h im alive on 2-2 1947

| Immediate cause of death | Duration |
|---|---|
| Pulmonary tuberculosis with Pulmonary Hemorrhage | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F F Schrader M. D.
Address Baltimore City Hospitals Date signed 2-2-47

X

G48209 CWK-10749 67455 BCH

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G48209

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitlas
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 Days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 311 Colfax Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy Carter-Emma

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 10-1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 14 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Arnett Carter
13. Birthplace ?

MOTHER
14. Maiden Name Emma Fokkes
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
Address

19 (a) FEB 3 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH January 24 19 47, at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 19 47, to Jan. 24 19 47, and that I last saw him alive on Jan. 24 19 47.

| Immediate cause of death | Duration |
|---|---|
| Gastrointestinal Hemorrhage | 2 days |
| Due to Prematurity | life |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter E. Hughes M. D.
Address Balto City Hosp Date signed Jan 27 '47

G48210

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46E

G48210 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2811 Clifton Ave.
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County ----------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2811 Clifton Ave. (If rural give location)
(e) Citizen of foreign country? ---------- (Yes or No)
If yes, name country ----------

**3 (a) FULL NAME** Mary Elizabeth Wills

3 (b) If veteran, name war ----------
3 (c) Social Security Account No. ----------

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife ----------
6 (c) If alive, give age --- years
7. Birth date of deceased (mo., day, yr.) ----------

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| About 62 | -- | -- | -- hr. -- min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business ----------

FATHER
12. Name Francis H. Wills
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Digges
15. Birthplace Maryland

16 (a) Informant John T. Wills
(b) Address 4301 Liberty Hgts. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/47 (month) (day) (year)
(c) Cemetery ###### St. Ignatius Church
Location Bel Alton, Md.

18 (a) Funeral director H. H. Mears & Son
(b) Address 1945 N. Calvert St.

FEB 3 1947
(Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1 1947, at 6 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946, to Feb 1 1947 and that I last saw h[illegible] alive on Jan 31 1947.

| Immediate cause of death | Duration |
|---|---|
| Terminal Pneumonia | 2 days |
| Due to Carcinoma of Sigmoid | 15 Mo. ? |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. P. VanSchwerdtfeger M. D.
Address 4818 Edmondson Ave Date signed 2/3/47

G48211 BALTIMORE CITY HEALTH DEPARTMENT G48211

# CERTIFICATE OF DEATH 838

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3405 Greenway
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3405 Greenway
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** George Edwin Dowell Jr.

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Honnie C. Dowell

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Oct 10 1866

8. AGE: Years 80 | Months 3 | Days 23 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business –

FATHER
12. Name Geo. E. Dowell
13. Birthplace Balto Md

MOTHER
14. Maiden Name Emma Nalls
15. Birthplace Balto. Md.

16 (a) Informant Mrs Honnie C. Dowell-(wife)
(b) Address 3405 Greenway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-4-47 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Stewart Memorial,
(b) Address 108 W Mount Ave.

19 (a) – 1947 (b) (Date rec'd by registrar) Registrar

Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 2 1947 at 11:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 17 1943 to Dec 2 1947 and that I last saw him alive on Dec. 1 1947

| | Duration |
|---|---|
| Immediate cause of death Cerebral Hemorrhage | 9 days |
| Due to Arteriosclerosis - General and cerebral | 12 yrs |
| Due to | |
| Other Conditions Parkinsonism | 10 yrs |

(Includes pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Holmes Dorsey M.D.
Address 24 E. Eager St Date signed 2/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G48212

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 56B

G48212 Registered No.

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave & Pulaski St
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Y
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 325 Gorsuch Ave (If rural give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country

3 (a) FULL NAME Antoinette A. Matulionis = "Matuliavis"

3 (b) If veteran, name war WAC — II

3 (c) Social Security Account No. 214-16-6416

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Vincent E. Matulionis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 28-1908

8. AGE: Years 38 | Months 1 | Days 3. | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Machine Operator

11. Industry or business Corset Foundation

FATHER 12. Name Anthony Lorashevich

FATHER 13. Birthplace Russia

MOTHER 14. Maiden Name Anna Elaine

MOTHER 15. Birthplace Russia

16 (a) Informant Vincent E. Matulionis

16 (b) Address 325 Gorsuch Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2/4/47 (month, day, year)

17 (c) Cemetery or crematory Loudon Park Location Baltimore Md.

18 (a) Funeral director J. B. Wilkinson Son

18 (b) Address 300 Eutaw Place

19 (a) ___ (Date rec'd by registrar) (b) ___ Registrar

FEB 5 - 1947

VS 152

Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 31 1947, at 3 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1947 to Jan 31 1947 that I last saw alive on Jan 22 1947

| Immediate cause of death | Duration |
|---|---|
| Cardio-respiratory failure | |
| Due to Intestinal Obstruction | 8 days. |
| Due to Post-operative for Supra-cervical Hysterectomy for | |
| Other Conditions (A) Vitamin Myoma | 8 days. |
| (Include pregnancy within 3 months of death) | |
| Date of operation 1-22-47 & 1-28-47 | |
| Major findings of operation (A) Vitamin myoma (B) Chol. inclusion | |
| of autopsy: None | |

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Farber M. D.

Address Bon Secours Hosp. Balto. Md. signed 1-31-47

X

G48213

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G48213 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland — Union Mem. Hosp
(b) Street address — St Johns Church
(c) Hospital or institution — Fech. ave + South Road
(d) Length of stay in hospital or inst. (yrs., mos., or days) — Dead on arrival at Memorial Hosp
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 Sulgrave Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No) — If yes, name country — yes

3 (a) FULL NAME Wallace E Ford

3 (b) If veteran, name war — No
3 (c) Social Security Account No.

4. Sex — M
5. Color or race — White
6 (a) Single, married, widowed, or divorced — Married
6 (b) Name of husband or wife — Mary Beaghuman
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) — Nov 29, 1890
8. AGE: Years — 56; Months — 2; Days — 5; If less than one day — hr. — min.
9. Birthplace — Upper Tennant Maryland (Town, county, and state)
10. Usual Occupation — Passenger Agt Penna RR
11. Industry or business — Penna RR.

FATHER
12. Name — William Ford
13. Birthplace — Somerset County, Md.

MOTHER
14. Maiden Name — Lucy Ford
15. Birthplace — Somerset County, Md.

16 (a) Informant — Mrs. Wallace E. Ford
(b) Address — 1709 Sulgrave Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof — Feb. 5, 1947 (month) (day) (year)
(c) Cemetery or crematory — Lorraine Cemetery
Location — Woodlawn, Md.

18 (a) Funeral director — Rogers Lanahan
(b) Address — 4510 Liberty Heights Ave.

19 (a) 1947 (Date rec'd by registrar) — Huntington Williams, Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH — Feb 4 1947; at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to 2/4 1947, and that I last saw h alive on Jan 31 1947.

Immediate cause of death — Syncope death — acute heart failure — Duration: 6 mos.

Due to — Coronary Sclerosis with occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature — E. McLean

Address 705 Med Arts Date signed 2/7/47

X

G18214
AB-93888

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. G18214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr. 9mos.-3days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 217 President Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** George Washington Maykrantz

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Widower |

6 (b) Name of husband or wife Margaret (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22-1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 11 | 9 | hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Theodore Maykrantz
13. Birthplace York, Pennsylvania

MOTHER
14. Maiden Name Sophie Airdane
15. Birthplace Bavaria

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 2/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

FEB 4 - 1947 (b) Washington Williams, M.D.
Date rec'd by Registrar Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1- 1947, at 9.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-28 1945 to 2-1- 1947, and that I last saw h im alive on 2-1- 1947

| Immediate cause of death | Duration |
|---|---|
| Confluent Bronchopneumonia (4) | 2 days |
| Due to Pulmonary Edema. | |
| Due to Hypertensive C-V Disease. | |
| Other Conditions Nephrosclerosis | |
| C-V accident, old. Rt. | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy as above.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert A. Faulve M. D.
Address Balto City Hosps. Date signed 2-3-47

VS 150

X

G48215 UDRES

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G48215 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins 6th

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6M
(e) Length of stay in Baltimore (yrs., mos., or days) 60A

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 220 N. Castle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT UDRES (UDRIS)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Bertha Udres

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 60 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Bertha Udres
(b) Address 220 N. Castle St

17 (a) Burial (b) Date thereof Feb 6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Jewish Russian Jews
Location Baltimore

18 (a) Funeral director Fred W Ozarzewski
(b) Address 1930 Eastern Ave.

19 (a) FEB 4 - 1947 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 181

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/3/47 19..... at 3:00 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Ward M.D.
Medical Examiner.
Date signed 2/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48216

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 183

Registered No. G48216

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 Partridge Court- O'Donnell Heights (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MILLARD FRANKLIN THOMAS

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Married |

6 (b) Name of husband or wife Elizabeth Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1915

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 32 | | | hr. min. |

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Steel Laborer
11. Industry or business

FATHER
12. Name Oscar Thomas
13. Birthplace Va

MOTHER
14. Maiden Name Fannie Pilson
15. Birthplace Va

16 (a) Informant Elizabeth Thomas
(b) Address 1506 Partridge Ct-Balto 24

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 2-4-47 (month), (day), (year)
(c) Cemetery or crematory Pine Virginia
Location Pine Virginia

18 (a) Funeral director Rayner Sanders
(b) Address 1413 E. Preston St

FEB 4 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Jan. 31, 1947 at 7.05 P M

**21.** I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

**IMMEDIATE CAUSE OF DEATH** Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-31-47 at 5.10 P. M. 4/1
(b) Where did injury occur? Liberty ship Pier #5- Pratt St.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial (Public) While at work? Yes
(d) Means of injury Fell from scaffold of ship into harbor

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 2-1-47

VS 151

G18217

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G18217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd St & Calvert
(c) Hospital or institution: Union Memorial Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 ds
(e) Length of stay in Baltimore (yrs., mos., or days) lifetime

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2200 Park Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Rose R. Hummel

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | Wh | Wid |

6 (b) Name of husband or wife Benno W. Hummel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-13-1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 6 | 20 | hr. min. |

9. Birthplace Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Levi Rosenaur
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Slesinger
15. Birthplace Germany

16 (a) Informant Melvin R. Hummel
(b) Address 2200 Park Ave, Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/47. (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Hebrew
Location Balto Prov.

18 (a) Funeral director David Sandheim & Son
(b) Address 1902 Eutaw place

19 FEB 4 - 1947 Registered by Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 2 1947, at 3 00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3 1947 to 2-2 1947 and that I last saw h.er alive on 2-2 1947

| Immediate cause of death | Duration |
|---|---|
| Myocardial failure | 10 yrs. |
| Due to Hypertensive cardiovascular disease | 4 yrs |
| Due to | |
| Other Conditions Bronchopneumonia | 2 wks |
| Rt hemiplegia (1 mo) (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN.** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward H. Jones jr. M.D.
Address Union Mem. Hosp. Date signed 2-2-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48218

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 166

Registered No. G48218

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 Etting St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARY F. HARRIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Colored | married |

6 (b) Name of husband or wife Luther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1912

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 34 33 | 8 | 24 | hr. min. |

9. Birthplace Lancaster Co. Va (Town, county, and state)

10. Usual Occupation Housemaid

11. Industry or business

FATHER
12. Name Charles Penn
13. Birthplace Lancaster Co. Va

MOTHER
14. Maiden Name Sarah Higgins
15. Birthplace Lancaster Co. Va.

16 (a) Informant Mrs. Elizabeth Nutter
(b) Address 5550 Aileen St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 6, 1947 (month) (day) (year)
(c) Cemetery or crematory Columbus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Chas. H. Hyde
(b) Address 1603 Druid Hill Ave.

19 (a) Date received by registrar FEB 4 1947 (b) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 1, 1947 at 1 p. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of lung and heart

Due to

Other Conditions Bullet wound of 3rd dorsal vertebra (back bone) (Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-1-47 at 10.35 p. M.
(b) Where did injury occur? 1620 Etting St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature Howard J. Madeira M.D. Medical Examiner.
Date signed 2-3-47

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C48219

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 108

C48219 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1319 Madison Ave.
(c) Hospital or institution: H

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1319 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Fannie Dorsey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16 1864

8. AGE: Years 82 | Months 6 | Days 15 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph Garrett
13. Birthplace Maryland

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Samuel Dorsey
(b) Address 1319 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 4, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lucy A. Holland
(b) Address 1631 Daniel Hill Ave.

FEB 4 1947 (b) Huntington Williams
(Date received by local registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/31/47 19 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/29/47 19 to 1/31/47 and that I last saw her alive on 1/31/47

Immediate cause of death: Lobar Pneumonia — Duration

Due to: Cyanosis

Due to: Hemiplegia

Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide?
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Barksdale
Address 5424 Loney Ln. Date signed 2/4/47

VS 150

G48220

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 170c

Registered No. G18220

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 131 Enon Alley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** RICHARD HOES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife: Ella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 15, 1885

8. AGE: Years 61 62 | Months 5 | Days 18 | If less than one day hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Mechanic

11. Industry or business

FATHER
12. Name: Charles G. Hoes
13. Birthplace: Balto. Co. Md.

MOTHER
14. Maiden Name: Rachel Hood
15. Birthplace: Balto. Co. Md.

16 (a) Informant: Mrs. Annie Bishop
(b) Address: 1019 Providence St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 5, 1947 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn
Location: Baltimore, Md.

18 (a) Funeral director: Chas. J. H. Hall
(b) Address: 659 Druid Hill Ave.

19 (a) (Licensed embalmer) (b) Huntington Williams, M.D. Registrar

FEB 4 1947

VS 181

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 2, 1947, at 3.25 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Fractures of right clavicle, rt. ribs, pelvis, and right leg.

Due to

Other Conditions: Syphilitic aortitis; syphilitic heart disease; edema of lungs
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following: 11/2
(a) Date of injury 1-22-47 at 8.15 p. M.
(b) Where did injury occur? Dolphin & John St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
Means of injury: Pediastrian-struck by auto

23. Signature: George L. Merrill Medical Examiner. M.D.
Date signed 2-3-47

X

G48221

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 77E

G48221 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hospital 14 Dou
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. #517 Bloom Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME NATHANIEL BANKS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1914

8. AGE: Years 32 | Months 5 | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Thomas Banks
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Lydia Banks
15. Birthplace Essex Co. Va

16 (a) Informant Mrs. Lydia Banks
(b) Address 517 Bloom St.

17 (a) Burial (b) Date thereof Feb. 4, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lee A. Wallace
(b) Address 1631 Druid Hill Ave

19 (a) Filed Feb 4 1947 Huntington Williams, M.D.

VS 181

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** January 31, 1947, at 10 P.M.

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary edema, Alcoholism.

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury.....

23. Signature George F. Merrill M.D.
Medical Examiner.
Date signed 2/1/47

G48222
508985

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131B

Registered No. G48222

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 321 W. Hoffman St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Hubert Gordon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Anna S.

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) 1-1-1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 1 | 2 | hr. min. |

9. Birthplace: British W. Ind.
(Town, county, and state)

10. Usual Occupation: Cook

11. Industry or business

FATHER
12. Name: William Gordon
13. Birthplace: British W. I.

MOTHER
14. Maiden Name: ? ?
15. Birthplace: ?

16 (a) Informant: Mrs. Georgia Gordon
(b) Address: 321 W. Hoffman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 6, 1947 (month) (day) (year)
(c) Cemetery or crematory: Arbutus Mem. Pk.
Location: Baltimore Co. Md.

18 (a) Funeral director: Chas. H. Hall
(b) Address: 1601 Druid Hill Ave.

19 FEB 4 - 1947 (Date rec'd by registrar) Huntington Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 29 1947 to Feb. 3 1947 and that I last saw him alive on Feb. 3 1947.

| Immediate cause of death | Duration |
|---|---|
| Uremia | |
| Due to Chronic nephritis | |
| Due to | |
| Other Conditions Pneumonia, Cardiac failure | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. J. Dubois M. D.
Address Johns Hopkins Hospital Date signed 2-3-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48223 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G48223

# CERTIFICATE OF DEATH

DUPREY ✓ 937

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1812 Maryland
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 Maryland Avenue (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** WILFRED DU PREY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1000

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 47 | | | hr. min. |

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name James Du Prey
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Lillian King
(b) Address 806 Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/4/47 (month) (day) (year)

(c) Cemetery or crematory Bates Natnal
Location Bates Md

18 (a) Funeral director Isaiah L. Brandon
(b) Address 1048 W Mulberry St

FEB 4 - 1947 (Date rec'd by registrar) Huntington Williams, Md. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/26/47 19 , at 1:10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocarditis & Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John L. Weaver M.D. Medical Examiner.
Date signed 1/27/47

VS 191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48224

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. G48221

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 117 Welcome Alley (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME: Henry Strickland

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 65 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Harvey Lee
(b) Address 541 Barre St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Bates Md

18 (a) Funeral director Isaac L Brannon
(b) Address 1086 Montgomery St

19 (a) FEB 4 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27, 1947, at 10.35 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, Spontaneous

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Howard J. Mullen M.D. Medical Examiner.
Date signed 1-27-47

VS 181

G18225

AB-100966

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13B

Registered No. G18225

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 6-4
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5mos. & 10days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 423 N. Ann Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Zolda Briggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1922

8. AGE: Years 24 | Months 4 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alexander Briggs
13. Birthplace Va.

MOTHER
14. Maiden Name Flossie Taylor
15. Birthplace Va.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 6, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Elroy S. Wilson
(b) Address 1006 Broadway ave Huntington Station N.Y.

19 FEB 4 - 1947 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2- 1947, at 2.45P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-22- 1946 to 2-2- 1947, and that I last saw h- er alive on 2-2- 1947.

Immediate cause of death: Pulmonary Tuberculosis — Duration 7 Mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F S Chaffee M. D.
Address Baltimore City Hospital Date signed 2-3-47

VS 150

G48226

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

Registered No. G48226

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 643 W. Barre St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 643 W. Barre St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John White

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Col. | Widowed |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | 6 | 21 | hr. min. |

9. Birthplace Accomac Co., Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name Lina White
15. Birthplace Va.

16 (a) Informant Cordillia White
(b) Address 643 W. Barre st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1600 Grant Lane

FEB 4 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 15 1947 at 12 Noon

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1947 to Jan 15 1947 and that I last saw him alive on Jan 15 1947

Immediate cause of death: Cerebral Hemorrhage — Duration 7 hr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Williams M.D.

Address Date signed 2/3/47

G18227
AB-10795

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

X V
92B

Registered No. G18227

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 214 Riverside Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Showalter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7- 1894

8. AGE: Years 52 | Months 11 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Stove-crate inspector

11. Industry or business

FATHER
12. Name Milton Showalter
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Catherine Smith
15. Birthplace Baltimore, Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 6- (month) (day) (year)
(c) Cemetery or crematory Balto National
Location C Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2015 Orleans St

19 (a) FEB 4 - 1947 (Date rec'd by registrar)
Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3- 1947, at 6.55A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-27 1947, to 2-3- 1947, and that I last saw h im alive on 2-3- 1947

| | Duration |
|---|---|
| Immediate cause of death Cardiac Failure. | |
| Due to Rheumatic Mitral + Aortic Disease. | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert R. Fackler M. D.
Address Balto City Hosp Date signed 2-3-47

X

G48228

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48228 Registered No. 1216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3905 Woodley Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 77 yr.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3905 Woodley Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Francis Marion Newkirk.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | white | married. |

6 (b) Name of ~~husband~~ or wife Henrietta Newkirk
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) October 14, 1869

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 3 | 20 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Francis Marion Newkirk
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Lucretia Hudgins
15. Birthplace Mathews Co. Va

16 (a) Informant Francis Earl Newkirk
(b) Address 3905 Woodley Ave.

17 (a) Burial (b) Date thereof Feby 6.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location City

18 (a) Funeral director Sellers & Funeral Home
(b) Address 2008 Orleans St

19 (a) FEB 4 - 1947 Registrar
(Date rec'd by registrar)

VS 8

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 3 1947, at 8:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from December 1946 to Feb. 3 1947. and that I last saw him alive on Feb. 1 1947.

| Immediate cause of death | Duration |
|---|---|
| Uremia | 1 week |
| Due to Acute exacerbation ch. Nephritis | 3 mo. |
| Due to | |
| Other Conditions Blindness | |

(Include pregnancy within 3 months of death)

Date of operation no.
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James C. Straley Jr. M. D.
Address 29 E. Baltimore St. Date signed 2/5/47

G48229

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

Registered No. G48229

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 808 Cathedral St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 808 Cathedral St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** WESLEY WALDVOGEL

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 215-24-5192

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Dorothy Eleanor Suwall Waldvogel
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 2, 1901
8. AGE: Years 46 | Months 0 | Days 29 | If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Interior Decorator
11. Industry or business Self

FATHER
12. Name Henry C. Waldvogel
13. Birthplace Germany

MOTHER
14. Maiden Name Mary L. Arthur
15. Birthplace New Jersey

16 (a) Informant Mr. Bruno A. Suwall, brother-in-law
(b) Address 2318 Longwood St.

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof 2/4/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore Maryland

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 4 - 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 1, 1947, at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6, 1946, to Feb 1 1947. and that I last saw him alive on Feb. 1 1947.

Immediate cause of death Coronary occlusion — Duration 24 hours

Due to Arteriosclerosis — Duration ?

Due to

Other Conditions Primary coronary thrombosis causing part of several years.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Douglas Lobaugh M. D.
Address 20 E Cathedral St Date signed 3 Feb 1947

VS 150

G48230

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

Registered No. G48230

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution:
Mary Land General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2024 Calvert St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Frank Brown Smith

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | white | married |

6 (b) Name of husband or wife Lizette Smith
(nee Yost) 6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 5, 1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | 2 | 27 | hr. min. |

9. Birthplace Baltimore, Baltimore Md.
(Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business self

FATHER
12. Name George M. Smith
13. Birthplace Phoenix, Md.

MOTHER
14. Maiden Name Ida B. Seitz
15. Birthplace Bowie, Md.

16 (a) Informant Lizette Smith
(b) Address 2024 Calvert St.

17 (a) Burial (b) Date thereof 2/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Filed Feb 4 1947 (Date received by local registrar) Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 2 19 47 at 1:53 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw him alive on Feb 2 19 47.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | |
| Due to Hypertension | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward J. Burkhart M. D.
Address Md. Gen'l Hospital Date signed Feb 3, 47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48231

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 55E

Registered No. G48231

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1228 W.Lanvale St.
(c) Hospital or institution: 14
D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1228 W.Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** FREDERICK WARD

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. divorced

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/15/1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 54 | 7 | 18 | hr. min. |

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name Charles Ward
13. Birthplace Md.

MOTHER
14. Maiden Name Susan Wilson
15. Birthplace Md.

16 (a) Informant Susan Ward
(b) Address 1228 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/47 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Presstman St.

19 (a) FEB 4 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 3, 1947, at 9.35 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of neck

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrell M.D.
Medical Examiner.
Date signed 2/3/47

G18232

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 33a

Registered No. G18232

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1636 Millington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1636 Millington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

**3 (a) FULL NAME** Joseph Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10 1893

8. AGE: Years 54 | Months | Days 22 | If less than one day hr. min.

9. Birthplace Charles Co. Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Ada Porter

(b) Address 1636 Millington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 5. 1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem.

Location Brooklyn Md

18 (a) Funeral director Chas O. Wilson

(b) Address 1510 Mclean Ave

19 (a) (Date rec'd by Reg.) (b) Huntington Williamsport Registrar

FEB 4 - 1947

## MEDICAL CERTIFICATION

2/1/47 2:45 P.M.

20. DATE OF DEATH 2/1 — 1947 2:45 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 1/1 1947 to 2/1 1947 and that I last saw him alive on 2/1 1947.

Immediate cause of death Lobar Pneumonia — Duration 14 days

Due to Stupor & Uremia — 24 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jas R Blake M. D.

Address 327 E. Central Date signed

X 2-4-47.

G48233

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

8-2a

G48233
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Greenway Apts. Charles & 34th Sts.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 66 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Charles & 34th Sts.
(If rural give location)
(e) Citizen of foreign country? --- (Yes or No)
If yes, name country ---

3 (a) FULL NAME: John T. O'Mara

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Josephine Larkin

6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) June 28, 1880

8. AGE: Years 66 | Months 7 | Days 7 | If less than one day --- hr. --- min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Doctor of Medicine

11. Industry or business:

FATHER
12. Name: Edward O'Mara
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Honorah Fitzgerald
15. Birthplace: Ireland

16 (a) Informant: Mrs. Josephine L. O'Mara
(b) Address: Greenway Apartments

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/47 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore, Md.

18 (a) Funeral director: Wm. J. Meade and Son
(b) Address: 805 N. Calvert Street

FEB 4 - 1947 (Date filed by Registrar) Huntington Williams M.D. (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 3 1947, at 11 a. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1946 to Feb 3 1947 and that I last saw alive on Feb. 3 1947.

Immediate cause of death: Cerebral Hemorrhage Duration 2 hrs
Due to: Cerebral Arteriosclerosis
Due to: Chr. Arterial Hypertension
Other Conditions contributing but not related to cause given: Tuberculosis Cerebral Humor. Vessels.
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Carroll Stockard M. D.
Address: 2925 N. Charles St. Date signed: 2-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48234

BALTIMORE CITY HEALTH DEPARTMENT Dr. M. Adams G48234
Registered No.

# CERTIFICATE OF DEATH 94a

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1020 Sterling St
(c) Hospital or institution: 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 Sterling Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Willie May Howard

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | Col | Married |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 28 1892

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | | 5 | hr. min. |

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name John Allen
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Allen
15. Birthplace Virginia

16 (a) Informant Estella Curtis
(b) Address 1804 N Spring St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) 2-6-47
(c) Cemetery or crematory Mt Calvary Cem
Location B. G. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1112 E. Preston St

19 (a) [illegible] (b) Huntington Wills [illegible] M. D.

VS 190

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 2, 1947 at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-47 19..., to 2-2- 19 47 and that I last saw h.r alive on 2-1-47 19...

Immediate cause of death Coronary Thrombosis — Duration 8 hr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marion Adams, M. D.
Address 231 N. Grey St Date signed 2-9-47

X

G48235

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

Registered No. G48235

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1713 W. Lanvale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 W. Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Clara Boardley

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Col. | Widow |

6 (b) Name of husband or wife Richard Boardley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 1 | - | hr. min. |

9. Birthplace St. Mary's Co. Md
(town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Gross
13. Birthplace Md.

MOTHER
14. Maiden Name Edmonia Bennett
15. Birthplace Md

16 (a) Informant Carolyn Dorman
(b) Address 1723 W. Lanvale St

17 (a) Buried (b) Date thereof Feb. 4, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 322 W. Edmondson Ave.

FEB 4 1947 (b)
(Date received by Registrar) Registrar
Huntington Williams, M.D.

V S 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb 1 1947, at 7:30 A.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1947 to Feb 1 1947 and that I last saw h. alive on Feb 1 1947

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | |
| Due to Arteriosclerosis (secondary) | |
| Due to | |
| Other Conditions Acute Myocardial Failure | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature J. H. Banfield M. D.
Address 722 N. Fulton Ave Date signed 2/3/47

G48236

G48236

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93c

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland D.S.H.
(b) Street address 1101 W. Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 W. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Corrine Johnson (Howard Jones)

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | Colored | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1904

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 42 | 11 | 16 | hr. min. |

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Phil Jones
13. Birthplace St. Marys Co. Md.

MOTHER
14. Maiden Name Blanch Johnson
15. Birthplace Va.

16 (a) Informant Blanch Bell
(b) Address 1711 Pierce St.

17 (a) Burial (b) Date thereof Feb 5, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Pisgah Cem
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19. FEB 4 - 1947 (Huntington Williams, M.D.)
(Date rec'd by registrar)

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/2 19 47 at 10:20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Rheumatic Cardiovascular Disease
Auricular Fibrillation
Cardiac decompensation 9 yrs IV

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Seelman M.D.
Medical Examiner.
Date signed 2/2/47

G48237

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G48237

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 415 Woodlawn Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 Woodlawn Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DR. SAMUEL O. MAST

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Grace T. Mast
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1871

8. AGE: Years 75 | Months 3 | Days 28 | If less than one day hr. min.

9. Birthplace Washtenaw Co., ~~Mich~~ Michigan
(Town, county, and state)

10. Usual Occupation Doctor of Philosppby

11. Industry or business Johns Hopkins University

FATHER
12. Name F. F. Gottlobe Mast
13. Birthplace Germany

MOTHER
14. Maiden Name Beata Staebler
15. Birthplace Germany

16 (a) Informant Mrs. Grace T. Mast
(b) Address 415 Woodlawn Rd. 10

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 2/5/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Crem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 4 - 1947 (Date rec'd by registrar) Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3, 1947 at 9:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 1917 to Feb 3 1947 and that I last saw him alive on Feb 3 1947

Immediate cause of death: Coronary thrombosis — Duration: 5 days
Due to: Arteriosclerosis — 7 yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jno A Lutscher M. D.
Address 12 E Eager St Date signed Feb 4/47
LUETSCHER

V S 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48238

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G48238 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address ~~2315 Longwood St~~
(c) Hospital or institution:
MERCY HOSPITAL 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County —
(c) City or town BALT. 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2315 LONGWOOD ST.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** MRS. JOSEPHINE ABBOTT SCHANZE

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | WIDOWED |

6 (b) Name of husband or wife FREDERICK W. Schanze
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 3, 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 4 | 1 | hr. min. |

9. Birthplace MAINE.
(Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business

FATHER
12. Name WOODBERRY ABBOTT.
13. Birthplace MAINE.

MOTHER
14. Maiden Name LEVINE SEAVEY.
15. Birthplace MAINE.

16 (a) Informant Rev. J. T. Powers, Executor
(b) Address 1948 W. North Avenue

17 (a) Burial (b) Date thereof 2/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 4 - 1947 (b) Registrar
(Date rec'd by registrar)
Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH FEB. 7 1947 at 7:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from JAN. 29 1947 to FEB 7 1947 and that I last saw HER alive on FEB. 3 19 47.

| Immediate cause of death | Duration |
|---|---|
| CARDIO-RESPIRATORY FAILURE. | |
| Due to HYPERTENSIVE. | |
| Due to CARDIO-VASCULAR DISEASE. | |
| Other Conditions CONGESTIVE HEART FAILURE. | |
| (Include pregnancy within 3 months of death) Due to AURICULAR FIBRILLATION | |

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James A. Roberts M. D.
Address Mercy Hospital. Date signed 2-5-47

X

G48239

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G48239 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland Calvert St
(b) Street address (700 W. 41st omit # Balto #)
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W 41st St Balto. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs. Dora C. Mewshaw

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | — |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | widowed |

6 (b) Name of husband or wife Asa J. Mewshaw
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8. 1861

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 85 | 3 | 25 | 14 hr. 15 min. |

9. Birthplace Maryland (Howard Co.) (town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Harrison C W Kete
13. Birthplace Md (Howard Co.)

MOTHER
14. Maiden Name Mary Ellen Harwentter
15. Birthplace Md.

16 (a) Informant: Mrs. Mamye M. Aldridge
(b) Address 3040 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

FEB 4 - 1947 (Date rec'd by registrar)

19 (a) Filed by Wm. J. Tickner & Sons (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2-3 1947, at 2:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25 1947 to 2-3 1947 and that I last saw him alive on 2-3 1947

| Immediate cause of death | Duration |
|---|---|
| Diabetic Mellitus | |
| with Hypostatic Pneumonia | |
| Due to Stroke (14 hrs) | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurence J. Finn M. D.
Address Mercy Hosp. Date signed 2-5-47

VS 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48240

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

(over) 47

✓ Registered No. G48240

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3809 Hudson, St.
(c) Hospital or institution: 7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3809 Hudson, St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

**3 (a) FULL NAME** John A Reuter

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Ella M. Sommers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, (1890) 1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| (56) 57 | 8 | 9 | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Chemest
11. Industry or business

FATHER
12. Name William Reuter
13. Birthplace Unknown

MOTHER
14. Maiden Name Catherine Peetz
15. Birthplace Unknown

16 (a) Informant Ella M Reuter
(b) Address 3809 Hudson, St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Federick, Ave.

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 S. Wolfe, St. Balto. Md.

19 (a) FEB 4 1947 (Filed by registrar) Thurlington Williams, M.D. Registrar

V S-190

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 2 1947, at 4 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Nov. 1 1946 to Feb 2 1947 and that I last saw h alive on Feb 1 1947

Immediate Cause of death: Cancer of L. Lung (Johns Hopkins Hosp.) — Duration 4 mos.
Due to
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos E. Wilson M.D.
Address 3 W. Read Date signed 2-4-47

G48241

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

93D

Registered No. G48241

PRESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3319 Mueller, St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3319 Mueller, St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** HARRY H. ECKES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ida V. Hoefer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25 1877

8. AGE: Years 69 | Months 8 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name Peter Eckes
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Henry Eckes
(b) Address 3319 Mueller, St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/5/47 (month) (day) (year)
(c) Cemetery or crematory Mount Carmel
Location O'Donell, St.

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 S. Wolfe, St. Balto. Md.

19 (a) FEB 4 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 2 1947, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1946 to Feb 2 1947, and that I last saw h... alive on 2-2-1947.

| Immediate cause of death | Duration |
|---|---|
| Arteriosclerotic & C Disease | |
| Chronic Myocarditis | |
| Due to Cerebral Hemorrhage | 11-15-46 |
| Myocardial Failure | 2-2-47 |
| Due to | |
| Other Conditions None | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Eschenmeyer M.D.
Address 842 S. Ann St. Date signed 2-4-47

V S 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48242

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 49a

Registered No. G18242

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 22 Mallow Hill Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 Mallow Hill Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary V. Gerlach

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-2912

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1893

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | 8 | 14 | hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Instructor
11. Industry or business Marlboro Shirt Co.

FATHER
12. Name Casper A. Gerlach
13. Birthplace Md.

MOTHER
14. Maiden Name Julia Fox
15. Birthplace Md.

16 (a) Informant Mr. B. H. Gerlach
(b) Address 22 Mallow Hill Avenue

17 (a) Burial (b) Date thereof 2/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Avenue

(c) Filed FEB 4 1947 (d) Registrar Huntington Williams M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 3, 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 9 1944 to Feb. 3 1947 and that I last saw her alive on Feb. 2, 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardiac Failure | 1 mon. |
| Due to Adeno-carcinoma of the ovary | 3 yrs. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George A Kupp
Address 3030 Edmondson Ave. Date signed 2/4/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48243 (1937) Registered No. G48243

G48243

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto Genl. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 H
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County City
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1242 Battery Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Albert R. Baker

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 214-01-9769

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Sicholstiel

6 (c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): Jan. 5th., 1888

8. AGE: Years 59 | Months 10 | Days 29 | If less than one day: ____hr. ____min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Printers helper.

11. Industry or business: Printing Co.

FATHER
12. Name: Ruben Baker
13. Birthplace: Frederick, Md.

MOTHER
14. Maiden Name: Susan Mullen
15. Birthplace: Frederick, Md.

16 (a) Informant: Mrs. Mary G. Baker (Wife)
(b) Address: 1242 Battery Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/47 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Edmondson Ave. Balto: Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) FEB 4 1947 (Date received by registrar) (b) Huntington for Williams, M.D. Registrar

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Feb 4th 1947, at 12 20 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary occlusion

Due to: Hypertension Cardio-Vascular disease

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: William T. Hefferd M.D. Medical Examiner.
Date signed: 4 Feb 47

X

G48211 BC# B68936

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 159

G48214 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: President Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ days.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Harford
(c) City or town Rest of Joppa.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby ? Claudine Wallace

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Negro. | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-22-47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 1½ | hr. min. |

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Wallace

13. Birthplace Wash. D. C.

MOTHER 14. Maiden Name Claudine Boone

15. Birthplace Wash. D. C.

16 (a) Informant Claudine Wallace

(b) Address Joppa Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Johns Hopkins Medical School FEB 4 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 FEB 4 1947 Huntington Williams, M.D.
(Date rec'd by Registrar)

VS 190

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-24-1947, at 7:10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-22-1947 to 1-24-1947, and that I last saw h.... alive on 1-24-1947.

| Immediate cause of death | Duration |
|---|---|
| Prematurity | 2 hrs. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Louis Jones M. D.

Address 1101 Davis Bldg Date signed 1-24-47.

X

G48245
508957

BALTIMORE CITY HEALTH DEPARTMENT ✓ G48245 Registered No.
# CERTIFICATE OF DEATH 137a

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Dundalk Balto Co (If outside city or town limits, write RURAL and give town)
(d) Street No. South Vale Road (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

**3 (a) FULL NAME** Carter Burnette

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | |

6 (b) Name of husband or wife Francis Burnette
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1892

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 | 11 | 10 | ....hr. ....min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Franklin Burnette
13. Birthplace Virginia

MOTHER
14. Maiden Name Elizabeth Z
15. Birthplace Virginia

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 8 1947 (month) (day) (year)
(c) Cemetery or crematory Oak Grove Cemetery
Location Prince Georges County Va

18 (a) Funeral director Joseph A. Finely
(b) Address 66 W Lanvale St

Feb 7 1947 (Date rec'd by Registrar) (b) Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb. 3, 1947, at 5.05 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 29 1947 to Feb 3 1947 and that I last saw him alive on Feb. 3, 1947.

Immediate cause of death..... | Duration

Anesthetic Death (No Autopsial) | .....
Due to Respiratory Arrest (?) Cardiac | .....
Due to Anoxemia (?) | .....
..... | .....
Other Conditions BPH | .....

(Include pregnancy within 3 months of death)
Date of operation 2-3-47
Major findings of operation: BPH
Transurethral prostatic resection
of autopsy:.....

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence 2/3/47 at 5 P.M.
(c) Where did injury occur? Johns Hopkins Hosp (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public (Specify type of place) While at work? No
(e) Means of injury.....

**23.** Signature H. G. Dorsheimer
Address.....Date signed 2-4-47 M.D.

VS 150

For Dr. J. Lukomski, by Howard J. Conaway, M.D. ✓

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cause and age is especially important. Physicians: please write the causes of death clearly and legibly.

G48246

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 186a

G48246 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Church Home & Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 913 S. Fremont St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

**3 (a) FULL NAME** James SAMUELS

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-1091

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Unknown

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 72 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Old age Survivors

11. Industry or business Benefits.

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant William Liggetts

(b) Address 713 So Wendover Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 5 1947 (month) (day) (year)

(c) Cemetery or crematory Mount Auburn

Location Baltimore City

18 (a) Funeral director Joseph A. Lively

(b) Address 661 West Baltimore Street

19 (a) 1947 (Date filed by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH January 28, 1947, at 1 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ probably, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH.....
Chronic myocardial degeneration
Generalized arteriosclerosis.
Due to Old fracture of left femur.

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:

(a) Date of injury 11/10/46 at ? 8:10 A.M.

(b) Where did injury occur? [illegible]

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury [illegible]

23. Signature George G. Merrill M.D.
Medical Examiner.

Date signed 1/20/47

VS 181

G18247

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13B

Registered No. G18247

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: Us Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 9 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days): 30 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 600 St. Paul St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

**3 (a) FULL NAME:** Burke, Joseph Albany

3 (b) If veteran, name war: WWI
3 (c) Social Security Account No.: 212-09-8597

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 15, 1892

8. AGE: Years: 54 | Months: 5 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Everett, Boston, Mass. (Town, county, and state)
10. Usual Occupation: none
11. Industry or business:

FATHER
12. Name: Theodore L. Burke
13. Birthplace: Nova Scotia

MOTHER
14. Maiden Name: Frances Babin
15. Birthplace: Nova Scotia

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 8, 1947 (month) (day) (year)
(c) Cemetery or crematory: Church Cemetery
Location: Everette, Mass.

18 (a) Funeral director: Elmer W. Conklin, Son
(b) Address: 92 Hanover St. Williams, M.D.

4 (a) 1947 (Do not write in this space) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Feb. 4 1947, at 3:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 3 1947, to Feb. 4 1947, and that I last saw him alive on Feb. 4 1947.

Immediate cause of death: Pulmonary tuberculosis, chronic, apical, bilateral with multiple cavitation — Duration: LONG TIME

Due to:

Other conditions: Coronary arteriosclerosis with infarction left ventricle and aneurysm of the tip of the left ventricle — Duration: LONG TIME

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?: (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed 2/4/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48248

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X✓ G48248 46E

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 55
(e) Length of stay in Baltimore (yrs., mos., or days) 0

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County Harford
(c) City or town Cardiff
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] (Frances) Heaps

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife Nelson A Heaps
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-21-1869

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 10 | 14 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Hopkins
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Harper
15. Birthplace Maryland

16 (a) Informant Nelson A Heaps
(b) Address Cardiff, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 7 1947 (month) (day) (year)
(c) Cemetery or crematory Slate Ridge Cem
Location Delta, Pa
18 (a) Funeral director Herbert P Yorke
(b) Address Delta, Pa
19 (a) (Date received by Local Registrar) (b) Registrar

FEB 4 1947
Washington Hillsville, MD

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: 2-4- 1947 at 1.56 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-12 1946 to 2-4 1947 and that I last saw HEU alive on 2-4 1947

Immediate cause of death: Generalized Carcinomatosis — Duration 1 Year

Due to Carcinoma of Cecum — Duration ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature
Address Medical Arts Bldg Date signed 2/4/47 M. D.

Hosp. X

G48249

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

131 B

Registered No. G48249

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL)
(d) Street No. 303 Chaggat Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Samuel Felton (Bey)

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-07-8409

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/9/1900

8. AGE: Years 46 | Months 1 | Days 23 | If less than one day hr. min.

9. Birthplace N-C (Town, county, and state)

10. Usual Occupation Stevedore

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Samuel Felton (d)
(b) Address 1925 Hurlock Ave Hyde

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto Md

18 (a) Funeral director Chas H Corpus
(b) Address 570-12 Conventon Ave

19 (a) FEB 3 1947 (Date received by registrar) (b) Huntington Williams M.D.

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 2nd 1947, at 5 15 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Glomerular Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Helfrich M.D. Medical Examiner.
Date signed Feb 3, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48250 BCH 57154 54 — 111B — Registered G48250

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1117 Forrest st.
(c) Hospital or institution: 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 Forrest st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ronald J Harris

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife: —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 14, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 4 | 5 | 21 | 20 hr. min. |

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business Infant

FATHER
12. Name James Harris
13. Birthplace New York N.Y.

MOTHER
14. Maiden Name Mary Lunatyn
15. Birthplace Poland Ohio

16 (a) Informant Mary Lunatyn
(b) Address 1117 Forrest St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/47 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson Md

18 (a) Funeral director Fullwood Cook Inc
(b) Address 1217 E Fort Ave

19 (a) FEB 5 - 1947 (Date rec'd by registrar) Huntington W Baltimore, Md

VS 181

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4, 1947, at 7a. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Acute edema of lungs

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George B. Merrill M.D.
Medical Examiner.
Date signed 2-4-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G48251

~~G48251~~

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 Homewood Terrace (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Frederick William Stuehlau

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| None | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W. | W. Owned |

6 (b) Name of husband or wife Dead Nellie E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/21/60

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 87 | — | 13 | hr. min. |

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Frederick W Stuehlau
13. Birthplace Germany

MOTHER
14. Maiden Name Beta Jankowski
15. Birthplace Poland

16 (a) Informant Marguerite E Stuehlau
(b) Address 210 Homewood Terrace
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/47 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md
18 (a) Funeral director Tilhorn Funeral Home
(b) Address 1219 E Fort Ave
19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 FEB 5 - 1947 Huntington Williams, M.D.

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb - 3 - 1947, at 11 20 A. M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Feb - 2 - 1947, to Feb - 3 - 1947, and that I last saw ~~him~~ her alive on Feb - 3 - 1947.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Edema | |
| Due to Arteriosclerotic Cardio-Vascular Dis. | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry T. Tilhorn M. D.
Address U. M. H. Date signed 2/5/47

X

G48252

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G48252

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Road
(c) Hospital or institution: Ashburton House 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs/mo 5
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 809 PARK AVE.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** GRACE L. ROBINSON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W. | SINGLE |

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) JUNE 26, 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 7 | 7 | — hr. — min. |

9. Birthplace SALEM, NEW HAMPSHIRE
(Town, county, and state)
10. Usual Occupation TEACHER & AUTHOR
11. Industry or business COLLEGE

FATHER
12. Name REV. SAMUEL J. ROBINSON
13. Birthplace NEW YORK CITY

MOTHER
14. Maiden Name S. ELIZABETH GIBBS
15. Birthplace WISCASSET, MAINE

16 (a) Informant GERTRUDE ROBINSON (SISTER)
(b) Address 133 AVE B, N.Y.C.

17 (a) CREMATION (b) Date thereof FEB, 5, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) ~~Cemetery~~ or crematory GREENMOUNT
Location NORTH AVE., & GREENMOUNT

18 (a) Funeral director Walter Bayha Bradley
(b) Address 1922 W. North Avenue

19 (a) (b)
Date rec'd by Registrar FEB 5 - 1947 Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3 February 1947, at 10:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1947 to Feb 3 1947, and that I last saw h[illegible] alive on Feb. 3 1947

Immediate cause of death Chronic Myocarditis — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Futterman M. D.
Address 7324 Reisterstown Rd Date signed 2/4/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48253

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 117a

Registered No. G48253

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1804 W. Fra nklin St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 W. Franklin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** PERCY ~~Purdum~~ Pruden

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | C | Married |

6 (b) Name of husband or wife Odell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/14/1892

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 | 4 | 18 | 0 hr. min. |

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Railroad Employee
11. Industry or business

FATHER
12. Name Blunt ~~Purdum~~ Pruden
13. Birthplace Va.

MOTHER
14. Maiden Name Mamie Riley
15. Birthplace Va. Pruden

16 (a) Informant Odell ~~Purdum~~ (Wife)
(b) Address 1804 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/47 (month) (day) (year)
(c) Cemetery or crematory Cape Charles
Location Cape Charles Va.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 Carrollton Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 1 FEB 5 - 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/4/1947 19 at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Feb 4 1947. and that I last saw him alive on 2/4 1947.

| | Duration |
|---|---|
| Immediate cause of death Pulmonary Apoplexy | 2 hours |
| Due to Acute Alcoholism | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death).

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. Hankins M.D.
Address 416 N. Johns St Date signed 2/5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48254

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G48254 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 860 Vine St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 860 Vine St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thelma T. Lewis

3 (b) If veteran, name war No.

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Peter Lewis

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 11-17-1906

8. AGE: Years 40 | Months 2 | Days 16 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Chas Lilghman

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Ida Williams

15. Birthplace Va.

16 (a) Informant Peter Lewis (H)

(b) Address 860 Vine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/47 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location A.A. County, Md.

18 (a) Funeral director Charles G. Cooper

(b) Address 510-12 N. Carrollton Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

FEB 5 - 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-3- 1947, at 9 A M

21. I certify that I took charge of the remains described above, held an Autopsy • Inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Madison M.D. Medical Examiner.

Date signed 2-3-47

G48255

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH 46E

Reg. Dist. No.

G48255

**1. PLACE OF DEATH:**
County: 4100 N. Charles St.
City or town: Baltimore, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: County: 4100 N. Charles St.
City or town: Baltimore, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME:** George W. Slocum

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widower |

6.(b) Name of husband or wife: May Turner
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 29, 1854

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 92 | 4 | 5 | hrs. min. |

9. Birthplace: R. Island (Town, county, and state)
10. Usual occupation: Retired Broker
11. Industry or business:

FATHER
12. Name: Gardner B. Slocum
13. Birthplace: R. I.

MOTHER
14. Maiden name: Susan A. Sheffield
15. Birthplace: R. I.

16. Informant: Margaret B. Pilling
Address: 5160 N. Jofpa Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 5 1947 (month) (day) (year)
Cemetery or crematory: Prospect Cemy.
Location: Towson Md

18. Funeral director: John O. Mitchell & Sons
Address: 1900 Eutaw Place

19. FEB 5 - 1947 (Date rec'd by registrar) Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Feb. 3, 1947. 19 at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 19 47, to Feb 3 19 47
and that I last saw him alive on Feb 3 19 47

Immediate cause of death: Cancer of Cancerum
Antemortem diagnosis at 1st visit — DURATION: Oct 1946?
Due to:
Due to:
Other conditions: arterio-sclerosis
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas Clb Judd M. D. Grother
Address: 222 Wendover Rd Date signed: 2/5/1947

G48256

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

166

Registered No. G48256

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 Lorman Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Joseph R. Dean

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~. |
|---|---|---|
| Male | Colored | Married |

6 (b) Name of husband or wife Hazel Dean

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 41 | | | hr. min. |

9. Birthplace Westmoreland Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Joseph Thompson
13. Birthplace Va

MOTHER
14. Maiden Name Alice Dean
15. Birthplace Va.

16 (a) Informant Hazel Dean
(b) Address 1811 Lorman St

17 (a) Burial (b) Date thereof 2/6/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location A. A. Co. Md.

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 927 N. Mount St.

19 (a) FEB 5 - 1947 Huntington Williams, Jr.
(Date received by registrar)

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 4 1947, at 8 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage due to bullet wound of thoracic aorta, inferior vena cava

Due to Hand Given

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-4-47 at 8:15 A. M.
(b) Where did injury occur? 1600 blk. of Laurens St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms

23. Signature Howard J. Claudis M.D.
Medical Examiner.

Date signed 2-4-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48257
CMK-99089

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 113B

Registered No. G48257

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11- 29-
(e) Length of stay in Baltimore (yrs., mos., or days) 21- 8- 8-

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3213 Tate Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Isadore Elizabeth Kess

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25-1925

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 21 | 8 | 8 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Leon Columbus Kess
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Hooks
15. Birthplace North Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 2-6-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mayrthy
Location a a Co. Md

18 (a) Funeral director James A Davis
(b) Address 442 W. Hill St

19 (a) (Date received by Registrar) FEB 5 1947 (b) Signature for Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** February 3 1947, at 12:30 M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Feb. 2 1945, to Feb. 3 1947, and that I last saw her alive on Feb. 3 1947.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Tuberculosis | 2 |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Some

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. F. Schaefer M. D.
Address Baltimore City Hospitals Date signed 3 Feb 47

G48258

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

61

G48258

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Rayner ave. & Dukeland St.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 N. Longwood St.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs. Anna M. Day

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| *** | *** |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Roger T. Day
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 2 | 30 | 29 hr. min. |

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name J. Andrew Gruel
13. Birthplace Germany

MOTHER
14. Maiden Name ? Lindenburg
15. Birthplace Md.

16 (a) Informant Roger T. Day
(b) Address 701 N. Longwood St.

17 (a) Burial (b) Date thereof 2/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director Geo. W. Little
(b) Address 2700 Edmondson Ave.

19 (a) 1947 (b) Huntington, West Va.
(Date by day mail received) (Address)

FEB 3
VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb. 3, 1947 at 2:58 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from Nov. 25, 1946 to Feb 3, 1947
and that I last saw h[illegible] alive on Feb 3, 1947

Immediate cause of death: Cardio-respiratory-renal failure — Duration
Due to Uremia and arteriosclerosis
Due to Diabetes mellitus
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leon Toby M.D.
Address West Balto. Gen. Hosp. Date signed 2/3/47

G48259

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G48259

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Dukeland + Raylor Sts
(c) Hospital or institution: West Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 914 Franklintown Rd.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lillian Schanze

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-22-5713

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Geo. L. Schanze

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) October 15, 98

8. AGE: Years 48 | Months 3 | Days 19 | If less than one day hr. min.

9. Birthplace Frederick Md.
(Town, county, and state)

10. Usual Occupation Sales Girl

11. Industry or business Virginia Dare Candy

FATHER
12. Name Ira D. Hose
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Pierce
15. Birthplace Md.

16 (a) Informant Geo. L. Schanze
(b) Address 814 Franklintown Rd.

17 (a) Burial (b) Date thereof 2/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) FEB 5 1947 (b)
(Date received by registrar) Huntington Hillman Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-3 1947, at 3:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-3 1947 to 2-3 1947 and that I last saw h[illegible] alive on 2/3 1947

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertensive — Duration

Due to Heart Disease — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Sudranky M.D.
Address West Balto Hill Hosp Date signed 2/3/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48260 / 50 — Registrar's No. G48260

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2700 Winchester St.
(c) Hospital or institution:

16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2700 Winchester St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Hilda Wenger

3 (b) If veteran, name war: ***
3 (c) Social Security Account No.: ***

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife John F. Wenger
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) 12/17/1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 1 | 17 | hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Jacob Hausman
13. Birthplace Baltimore

MOTHER
14. Maiden Name Dora Smith
15. Birthplace Baltimore

16 (a) Informant John F. Wenger
(b) Address 2700 Winchester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Geo. W. Little
(b) Address 2700 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) 1947 (Registrar)

VS 150 FEB 5 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 3 1947, at 2.30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from May 11 1946 to Feb 3 1947. and that I last saw him alive on Feb 2 1947.

| Immediate cause of death | Duration |
|---|---|
| Epidermoid Carcinoma | |
| Due to carcinoma right breast | 3 years |
| Due to Breast | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 3 years ago
Major findings of operation: carcinoma
of autopsy: none

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edna A. Gearhart, M.D.
Address 1121 Dayton Ave. Date signed Feb 5 1947

G48261 BCH G60821

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1579

G48261 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland Boy Scouts Hosp

(b) Street address 1702 Holbrook St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9

(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1702 Holbrook St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** William Robert Willburn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 31, 1946

8. AGE: Years | Months: 3 | Days: 4 | If less than one day: hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wm. Emory Wilburn

13. Birthplace Balto

MOTHER 14. Maiden Name Merle McLamb

15. Birthplace N. Carolina

16 (a) Informant Mrs. Wilburn

(b) Address 1702 Holbrook St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 6, 1947 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore

18 (a) Funeral director Rita Wiedefeld

(b) Address 900 East Biddle St.

19 (a) [illegible] by Huntington Nothnagle, M.D. (Signature of registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 4 1947, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-21 1947 to 2-4 1947 and that I last saw him alive on 2-4 1947

| Immediate cause of death | Duration |
|---|---|
| Cardio-respiratory failure | |
| Due to Post-operative for Umbilical hernia | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation Jan. 22, 1947

Major findings of operation: Umbilical hernia

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Robert E. Farber M. D.

Address Bon Secours Hosp., Balto, Date signed 2-4-47

VS 180

X

G48262

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46B

Registered No. G48262

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4102 Parkside Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4102 Parkside Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Nicola Vitelozzi

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Alfredo Vitelozzi

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 12 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | | 22 | hr. min. |

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Pasquale Castagnetti
13. Birthplace Italy

MOTHER 14. Maiden Name Melinda Palamedessi
15. Birthplace Italy

16 (a) Informant William J. Vitelozzi
(b) Address 4102 Parkside Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-6-47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director John C. Melly Inc
(b) Address 2435 E. Oliver St

19 (a) (Date received by registrar) FEB 5 - 1947 (b) Huntingtown Williamsport Md.

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-3- 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17- 1941, to 2-3- 1947 and that I last saw her alive on 2-3- 1947

| Immediate cause of death | Duration |
|---|---|
| Gastric Cancer | 1 yr. |
| Due to | |
| Due to | |
| Other Conditions Generalised arteriosclerosis | 1941 |

(Include pregnancy within 3 months of death)

Date of operation Sept 1946

Major findings of operation: Gastric Cancer

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melton C. Lang M. D.
Address 2117 Belair Rd Date signed 2-4-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-10 G48263

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G48263

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs 2 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 322 N. Franklintown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Louis H. White

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-03-2584

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18- 1879

8. AGE: Years 67 | Months 2 | Days 15 | If less than one day ____hr. ____min.

9. Birthplace Pitt County, N.C.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Louis H. White Sr. (D
13. Birthplace N.C.

MOTHER
14. Maiden Name Martha Cox
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Mem
Location Frederick Ave

18 (a) Funeral director Cambiaso, Inc.
(b) Address 414 N. Franklintown Rd.

19 (a) FEB 5 1947 (Date rec'd by registrar) (b) Huntington-Pittsburgh

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3- 1947 at 10.10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1- 1947 to 2-3- 1947 and that I last saw him alive on 2-3- 1947

| Immediate cause of death | Duration |
|---|---|
| Respiratory Failure | |
| Due to Hypertensive C.V.D | |
| Due to | |
| Other Conditions Auricular Fibrillation | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund B. Beacham M.D.
Balto City Hosp Date signed 2-6-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BC# BALTIMORE CITY HEALTH DEPARTMENT

G48264 B66131 CERTIFICATE OF DEATH 119a

Registered No. G48264

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2219 Whitelock Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marlene Henda Rothbard

3 (b) If veteran, name war —

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 1 | 16 | hr. min. |

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Arthur Rothbard
13. Birthplace Balto Md

MOTHER
14. Maiden Name Eleanore Levy
15. Birthplace Scotland

16 (a) Informant Next of kin
(b) Address

17 (a) Burial (b) Date thereof 2-5-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Beth Tefiloh
Location Wendon Mill Rd

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St.

19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 5 - 1947

Kunkin for Hollander

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 4 1947 at 12 50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1947 to Feb 4 1947 and that I last saw her alive on Feb 4 1947

| Immediate cause of death | Duration |
|---|---|
| Diarrhea | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Francis D. Michael M.D.
Sinai Hosp Date signed 2/4/47

X

G48265

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G48265 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1714 Monument St.
(c) Hospital or institution: Sinai Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 Appleton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Goldstein

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife Mayer
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Kapel
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hospt Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-47 (month) (day) (year)
(c) Cemetery or crematory Rawlake
Location Phil Rd & Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 5 - 1947 Huntington Mitchell

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/4/47 19 at 10:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1/47 19 to 2/4/47 19 and that I last saw h.er alive on 2/4/47 19

| Immediate cause of death | Duration |
|---|---|
| Myocardial Failure | |
| Due to Arteriosclerotic Heart Disease | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ernest Scher
Address Sinai Hosp Date signed 2/6/47

Scher X

Med Exams Case G48266
H.L.H. Dist. G60706

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 161a

Registered No. G48266

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2018 Pennsylvania (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Henry Willie Gray

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/17/46

8. AGE: Years | Months 4 3 | Days 14 | If less than one day hr, min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Hinton Gray
13. Birthplace ?

MOTHER 14. Maiden Name Mary ?
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 5-1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn Va Croftes

18 (a) Funeral director Va Croftes
(b) Address 1437 N. Carey St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

FEB 5 - 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 1 - 1947 at 7 25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1947 to Feb 1 1947 and that I last saw h[illegible]live on Feb 1 1947

Immediate cause of death: CARDIAC FAILURE — Duration: 11 days

Due to

Due to

Other Conditions Atherosclerosis, Arterial
Left Lung
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Atherosclerosis, Left Lung

of autopsy: Cardiac Dilatation, Left Lung

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D W Higgins M.D.
Address Johns Hopkins Hospital Date signed 2-1-47

For O.J.R. Davis, by Howard J. Andrews, M.D.

G48267 F

AB-108108

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48267 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days

(e) Length of stay in Baltimore (yrs., mos., or days) 14yrs.

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 609 Aisquith St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

**3 (a) FULL NAME** William Mason Day

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charlotte

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14-1898

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 49 | 0 | 19 | hr. min. |

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Body and fender repair

11. Industry or business

FATHER
12. Name Andrew Day (D

13. Birthplace Va.

MOTHER
14. Maiden Name Clara Ferguson (D

15. Birthplace Va.

16 (a) Informant Records-Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Feb. 5-47 (month) (day) (year)

(c) Cemetery or crematory

Location Emporia, Virginia

18 (a) Funeral director Mrs Ida Bailey

(b) Address 1421 E. Jefferson st.

19 FEB 5 1947 (b) (Date rec'd by Registrar) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 3- 19 47, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1- 1947 to 2-3- 1947, and that I last saw h im alive on 2-3- 1947.

Immediate cause of death: Respiratory Failure — Duration: Days.

Due to: Bronchopneumonia

Due to:

Other Conditions: C.M.S. Syphilis, Anteriosterdis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edmund S Beacham M. D.

Address Balto City Hosp Date signed Feb 7th

X

G48268

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 167

Registered No. G48268

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 17
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 647- W. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** JAMES LITTLETON Curtis

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-5-1916

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 33 | 9 | 27 | hr. min. |

1913

9. Birthplace Princess Anne Md (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Earl F. Curtis
13. Birthplace Md

MOTHER
14. Maiden Name Estella Barnes
15. Birthplace Md

16 (a) Informant Luther Curtis
(b) Address 615 W. Saratoga St

17 (a) Removal (b) Date thereof 2-6-47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Hope Cem
Location Princess Anne Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania Ave

FEB 5 - 1947 (Date rec'd by registrar)

(b) Huntington Williams M.D. Registrar

VS 181

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 2nd, 1947 at 11:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Stab-wound of heart, with massive hemorrhage into
Due to pericardial and left
chest cavities

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2/2/47 at 11:15 A.M.
(b) Where did injury occur? 1335- Penna. Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Sharp instrument

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 2/3/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48269

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

131a

Registered No. G48269

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1628 Ralworth Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 Ralworth Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ANTONIO LOMBARDI

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | Widower |

6 (b) Name of husband or wife Agnes Lombardi
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 10 | 14 | hr. min. |

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation Retired Shoemaker
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mr. Anthony Lombardi
(b) Address 3508 Powhatan Ave.

17 (a) Burial (b) Date thereof 2/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Ave., Md.

FEB 5 - 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 3, 1947 at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19, 1934 to Feb. 3, 1947 and that I last saw him alive on Feb. 3, 1947

| | Duration |
|---|---|
| Immediate cause of death: Congestive Heart Failure | 24 hrs. |
| Due to: Hypertensive Cardiovascular Renal Disease | 12 yrs. |
| Due to: Arteriosclerosis | Unknown |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philip Artigiani M. D.
Address 2942 E. Fayette St. Date signed 2/4/46

X

G48270 BALTIMORE CITY HEALTH DEPARTMENT G48270
# CERTIFICATE OF DEATH 877
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 41 North Catharina St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 41 North Catharina St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

**3 (a) FULL NAME** FRANK J. EPPIG

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Emma C. Eppig
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | 8 | 21 | hr. min. |

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Balto. City Fire Dept.

FATHER
12. Name Joseph Eppig
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma Blakley
15. Birthplace Maryland

16 (a) Informant Mrs. Emma C. Eppig
(b) Address 14 North Catherine St.

17 (a) Burial (b) Date thereof Feb. 5, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Maryland

18 (a) Funeral director A. B. Shepherd & Son
(b) Address 1300 Eutaw Place 17

FEB 5 - 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 180

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 1, 1947 at P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/30 1946 to 2/1 1947 and that I last saw deceased alive on 1/31 1947

| Immediate cause of death | Duration |
|---|---|
| Pneumonia | 1 day |
| Due to Multipli Lobar | 5 yrs |
| Due to | over |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward A. Rushin M.D.
Address 2145 W. Balto St. Date signed 2/4/47

X

Dr. Carroza
G48271

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 1937

G48271
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4605 Kernwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4605 Kernwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** JAMES B. GREGORY

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Julia McGrath Gregory
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | | | hr. min. |

9. Birthplace West Virginia
(Town, county, and state)
10. Usual Occupation Railroad Engineer
11. Industry or business

FATHER
12. Name Thomas Gregory
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann Campbell
15. Birthplace Ireland

16 (a) Informant Mr. B. Gregory
(b) Address 4605 Kernwood Avenue

17 (a) Burial (b) Date thereof 2/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location City
18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVE. & 22ND

19 (a) FEB 3 1947 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 3rd 1947 at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1945 to Feb. 3 1947 and that I last saw h/M alive on Feb 2 1947.

Immediate cause of death: Arteriosclerotic - Hypertensive Cardio-vascular disease. — Duration: ?
Due to —
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Henry F Carroza M.D.
Address 5217 York Rd. Date signed 2/5/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48272

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 1937

Registered No. G48272

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 304 S. Norris St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Penna (b) County
(c) City or town Huntingdon Penna
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 Penn St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Elizabeth J. Green

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Wm Green

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 9, 1876

8. AGE: Years 70 | Months 11 | Days 26 | If less than one day hr. min.

9. Birthplace — (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name George Hearn
13. Birthplace ?

MOTHER 14. Maiden Name Caroline Norris
15. Birthplace ?

16 (a) Informant Della M. Holt
(b) Address 304 S. Norris St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 8-1947 (month) (day) (year)

(c) Cemetery or crematory
Location Huntingdon Penna

18 (a) Funeral director Pratt & B. M. Walters
(b) Address Pratt & Stuckey St

19 (a) (Date received) FEB 5 1947 Huntingdon Penna

VS 190

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** February 4 1947, at 1:20 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from Nov 1946, to Feb 4 1947, and that I last saw h[illegible] alive on Feb 3 1947.

| | Duration |
|---|---|
| Immediate cause of death Arteriosclerotic Heart disease | ? |
| Due to Generalized Arteriosclerosis | ? |
| Due to Age | |
| Other Conditions — | |

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Morris B. Schreiber M. D.
Address 5-4 S. Fulton Ave Date signed 2-5-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18273

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G18273

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2305 Maisel Street.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2305- Maisel Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** JOHN LITZ

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-9742

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Nettie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1893

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 | 11 | 30 | hr. min. |

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Lumbar

FATHER
12. Name Frederick Litz
13. Birthplace Scotland

MOTHER
14. Maiden Name Sophie Konetzki ?
15. Birthplace Germany

16 (a) Informant Nettie Litz
(b) Address 2305- Maisel St.

17 (a) Burial (b) Date thereof 2/8-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Rd.

18 (a) Funeral director Edward Lowland
(b) Address 1319 West Blvd

19 (a) FEB 5 1947 Registrar
(Date received by registrar)

VS 131

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 6, 1947, at 6.30 a M

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard A. Wallis M.D.
Medical Examiner.
Date signed 2-6-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48274

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48274 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 60 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. 131 Banbridge Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lopez, Alberto

3 (b) If veteran, name war

3 (c) Social Security Account No. 078-12-6847

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1888

8. AGE: Years 58 | Months 4 | Days 19 | If less than one day hr. min.

9. Birthplace Spain (Town, county, and state)

10. Usual Occupation Fireman-watertender

11. Industry or business Seafarer

FATHER 12. Name Earl Lopez
13. Birthplace Spain

MOTHER 14. Maiden Name Carmen Carnoga
15. Birthplace Spain

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Road

18 (a) Funeral director Lilly & Zerbe
(b) Address 403 S. Howard St.

19 (a) (Date rec'd by registrar) (b) Registration No. Williamsport

VS Form FEB 5 - 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 31 1947 at 12:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 2 1946 to Jan. 31 1947 and that I last saw him alive on Jan. 31 1947

Immediate cause of death: Carcinoma bronchogenic left lung with metastases to upper lobe right lung, heart Duem & pericardium, left adrenal — Duration: UNKNOWN

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

Autopsy: As above

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 2/5/47

X

Dr. Harding
4810 Belair Rd

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

47D

Registered No. G48275

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5011 Gunther Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) no
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5011 Gunther Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anna B. Friskey

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | married |

6 (b) Name of husband or wife George J. Friskey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 4 | 8 ? | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John Gunter
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Sadler
15. Birthplace Md.

16 (a) Informant Mr. George J. Friskey
(b) Address 5011 Gunther Avenue

17 (a) Burial (b) Date thereof 2/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5205 Harford Road

19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 5 - 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 3rd, 1947, at 6²² P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946, to 2/3 1947 and that I last saw her alive on 2/3 1947.

Immediate cause of death — Duration
Carcinoma Lung — 9 mo
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. S. Harding, M. D.
Address 4810 Belair Rd Date signed 2/4/47

X

Dr. Grott G48276

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G48276
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3110 Royston Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-3
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3110 Royston Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Oscar C. Cecil

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | widowed |

6 (b) Name of husband or wife Anna M. Cecil
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 8 | 10 | hr. min. |

9. Birthplace Eastern Shore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John M. Cecil
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Crosby
15. Birthplace Md.

16 (a) Informant Mr. John C. Cecil
(b) Address 3110 Royston Avenue

17 (a) Burial (b) Date thereof 2/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

FEB 5 - 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 4th, 1947, at 4.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/26 1946, to 2/4 1947, and that I last saw h. alive on 2/4 1947.

| Immediate cause of death | Duration |
|---|---|
| Acute pulmonary edema | 2 days. |
| Due to arteriosclerotic | |
| Due to cardio vascular di | 1 yr. |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold A. Gratt M. D.
Address 2700 Harford Rd Date signed 2/4/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G48277

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 61

G48277
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Howard & Madison St.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 68 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3412 Old York Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Edgar Ware Christie

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-9863

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 21, 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 0 | 5 | hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name James Christie
13. Birthplace Scotland

MOTHER
14. Maiden Name Caroline Ware
15. Birthplace Baltimore

16 (a) Informant Elsie Christie (Sister)
(b) Address 3412 Old York Road

17 (a) Burial (b) Date thereof 2/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Geo. L. Boyer Jr.
(b) Address 1512 Hollins St

(c) Date received FEB 5 - 1947 (by) Washington Williams, Registrar

VS 130

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 5 1947, at 1:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1947 to Feb 5 1947, and that I last saw h. alive on Feb 5 1947.

| Immediate cause of death | Duration |
|---|---|
| Congestive Hr. Failure | |
| Due to Diabetes Mellitus | |
| Due to Amputation rt. leg | |
| Other Conditions Diabetic + Gangrene | |

(Include pregnancy within 3 months of death)

Date of operation Jan 25 1947
Major findings of operation: Amputation rt. leg, below knee
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Ethel Phillips M. D.
Address Md. Gen. Hosp. Date signed Feb 5 '47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48278

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 157a

Registrar's No. G48278

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Ga. (b) County
(c) City or town Savannah (If outside city or town limits, write RURAL and give town)
(d) Street No. 318 E. Hall St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** William C. Broderick Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-6-46

8. AGE: Years | Months: 4 5 | Days: 28 | If less than one day: hr. min.

9. Birthplace Ga (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wm C. Broderick
13. Birthplace Ga

MOTHER 14. Maiden Name Mary Hennessy
15. Birthplace ?

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/5/47 (month) (day) (year)

(c) Cemetery or crematory
Location Savannah Ga

18 (a) Funeral director Geo. F. Bagley Jr
(b) Address 15-17 W Saratoga St

19 (a) Huntington Williams, Registrar (Date received by registrar)

FEB 5 - 1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 4 1947 at 4:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1947 to Feb 4 1947 and that I last saw him alive on Feb 4 1947.

Immediate cause of death: Operation - Shock — Duration: 2 Days

Due to: Operation - 3rd Ventriculostomy for Hydrocephalus

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A D Logan M. D.

Address Johns Hopkins Hospital Date signed 2-4-47

X

Birth Certificate

G48279 D-69041

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48279 Registered No. 1190

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2000 Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2000 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

**3 (a) FULL NAME** Baby Girl Duerr

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-27-47

8. AGE: Years — | Months — | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Duerr
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Gloria Knight
15. Birthplace Baltimore Md.

16 (a) Informant Joseph Duerr
(b) Address 1,605 Grantley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

19 (b) 2-5-1947 (Date rec'd by registrar) Clayton Williams, M.D. Registrar

VS 250

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 4, 1947, at 11:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-31-1947 to 2-4-1947 and that I last saw her alive on 2-4-1947.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Atelectasis | |
| Due to | |
| Other Conditions Gastro-enteritis (include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. L. Grantley M.D.
Address Bon Secours Hosp. Date signed 2-7-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G48280

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

137a

Registered No. G48280

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 208 S Vincent St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 -
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 208 S Vincent St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J Denson

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4 Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Julia A
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 17 1881

8. AGE: Years 66 | Months 0 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Denson
13. Birthplace Md

MOTHER
14. Maiden Name Catherine Moran
15. Birthplace Md

16 (a) Informant James L Denson
(b) Address 400 S Smallwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 8 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Cathedral
Location Baltimore Md

18 (a) Funeral director Gilbert & Lee
(b) Address 1219 Hoval St

19 (a) FEB 6 1947 (Date rec'd by registrar) (b) Huntington Hill, Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2, 1947 to Feb 4, 1947, and that I last saw him alive on Feb 2 1947

Immediate cause of death uremia — Duration 2 Months

Due to urinary obstruction — uncertain

Due to Prostatic Hypertrophy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Rawlin M. D.
Address 206 S. Gilmor St Date signed 2-5-47

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48281

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

G48281 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2116 E. Biddle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-4
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2116 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Conrad C. Kaltenhauser

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Mary
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Nov 5th 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 2 | 28 | hr. min. |

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation Tile Setter
11. Industry or business Monumental Tile Co

FATHER
12. Name George Kaltenhauser
13. Birthplace Germany

MOTHER
14. Maiden Name Anna C.
15. Birthplace Germany

16 (a) Informant Mrs. Mary Kaltenhauser
(b) Address 2116 E. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) FEB 6 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 3rd 1947 at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/3/47 1947 to 2/3 1947 and that I last saw h.i.m alive on 2/3 1947.

| Immediate cause of death | Duration |
|---|---|
| Respiratory Failure | |
| Due to Cerebral Hemorrhage | |
| Due to Hypertension | |
| Other Conditions Arteriosclerosis | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Kenneth Trulen M.D.
Address 2116 W Pratt St. Date signed 2/4/47

VS 150

G48282

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 48a

Registered No. G48282

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 W. Lexington St
(c) Hospital or institution:
Aged Women's & Aged Men's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Frances Benhoff Kirchner

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 3 2 | 23 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Benhoff
13. Birthplace

MOTHER 14. Maiden Name Rebecca Walker
15. Birthplace

16 (a) Informant Mrs. Wm. Read Supt.
(b) Address 1400 W. Lexington St.

17 (a) Burial (b) Date thereof 2/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Oak Lawn
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) FEB 6 - 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3rd 1947 at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/20 1929, to 2/3/ 1947, and that I last saw her alive on 2/2/ 1947.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of the cervix | about 1 yr. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin B. Jarrell.
Address 11 E. Chase St. Date signed 2/4/47

X

G18283 — 22 Series — Full Number G18283

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 127a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 926 N Calvert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 926 N Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert G Benson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife PAREPA Pearle G Benson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan - 5 - 1881

8. AGE: Years 66 Months 1 Days - If less than one day hr. min.

9. Birthplace W Va (State, county, and town)
10. Usual Occupation Coal Digger Retired
11. Industry or business

FATHER
12. Name Ezra D Benson
13. Birthplace W Va

MOTHER
14. Maiden Name Eva J Dietz
15. Birthplace W Va

16 (a) Informant Mrs Pearle G Benson
(b) Address 926 N Calvert St
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) 2/6/47
(c) Cemetery or crematory Terra Alta W Va
Location Terra Alta W Va
18 (a) Funeral director Fulton & Lee
(b) Address 1700 E Fayette St
19 (a) FEB 6 - 1947 (Date rec'd by registrar) (b) Huntington Williamson W Va

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 5 1947, 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Feb 4 1947 and that I last saw ~~him~~ alive on Feb 4 1947.

Immediate cause of death: Vesicae Fistula — Duration 1 yr
Due to Prostatectomy
Due to
Other Conditions Fracture Rt hip in Feb - 1946
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence February 1946 at ? M
(c) Where did injury occur? 926 N Calvert St (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Fell out of bed

23. Signature Howard J Greene M. D.
Address 711 Pendleton St Date signed

Howard J. Greene, M.D. X

VS 150

G48284

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1401B

Registered No. G48284

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2524 Maryland Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2524 Maryland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Margaret Hayes

3 (b) If veteran, name war

3 (c) Social Security Account No.

| Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 40 | | | hr. min. |

9. Birthplace Charles Town, W.Va. (Town, county, and state)
10. Usual Occupation Clerk - Government
11. Industry or business

FATHER
12. Name William J. Grimm
13. Birthplace Berryville, Va.

MOTHER
14. Maiden Name Dora Smallwood
15. Birthplace Marshall Va.

16 (a) Informant William J. Grimm
(b) Address Terra Alta, W.Va.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Jan 6, 47 (month) (day) (year)
(c) Cemetery or crematory
Location Terra Alta W.Va.

18 (a) Funeral director A. F. Callen
(b) Address Terra Alta W.Va.

19 (a) (Date rec'd by registrar) (b) Registrar

VS FEB 6 - 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 4, 1947, at 6 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Incomplete abortion followed by Septicemia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D. Medical Examiner.
Date signed 2-5-47

G48285

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 52 c

Registered No. G48285

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: Sinai Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 15 9
(e) Length of stay in Baltimore (yrs., mos., or days): 54

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: Md (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 4127 Fairview Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Joseph Schloss

3 (b) If veteran, name war: World War 11

3 (c) Social Security Account No.:

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sonia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 4/1892

8. AGE: Years 54 | Months 7 | Days 1 | If less than one day: hr. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation:

11. Industry or business: Salvage Business

FATHER
12. Name: Abraham Schloss
13. Birthplace: Russia

MOTHER
14. Maiden Name: Sophia
15. Birthplace: Russia

16 (a) Informant: Sonia Schloss
(b) Address: 4127 Fairview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb 6/47 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Friendship
Location: 3600 East Baltol St. Cemet

18 (a) Funeral director: Sol Levinson & Bros.
(b) Address: 1124-26 W. North Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

V FEB 6 - 1947

Huntington Hollins, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Feb 5 1947, at 9:24 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 27 1947, to Feb 5 1947, and that I last saw him alive on Feb 5 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration:

Due to: Chronic Pyelonephritis — Uremia & Hypostatic Pneumonia

Due to:

Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: L. Rosenbaum M.D.

Address: Sinai Hosp. Date signed: 2/5/47

X

G18286

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G18286

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1 E. Eager St.
(c) Hospital or institution:
Barber Shop of Md. Club. 27 11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4207 Linkwood Road. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** ISAAC R. PELS.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Margaret Black Pels.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1881.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 3 | 27 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Physician.

11. Industry or business

FATHER
12. Name Moses Pels.
13. Birthplace Germany.

MOTHER
14. Maiden Name Helen Rosenbaum,
15. Birthplace Phila. Pa.

16 (a) Informant Mrs. Margaret B. Pels,
(b) Address 4207 Linkwood Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/47. (month) (day) (year)
(c) Cemetery or crematory Druid Ridge.
Location Pikesville, Md.

18 (a) Funeral director Baird Sonnheim & Son
(b) Address 1902 Eutaw Place.

19 (a) Date received by registrar FEB 6 1947 (b) Huntington Williams, M.D. Registrar

VS 6

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4th. 1947 at PM

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy find that said deceased came to his death on the day stated above.

Immediate cause of death: Coronary Vascular Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John R. Evans, M.D. Medical Examiner.
Date signed 2/8/47

G48287 BCH

G69307-or

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓160a

G48287

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp. 1-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore Md
Franklin Square Hosp. (If outside city limits, write RURAL and give town)
(d) Street No. Calhoun & Fayette St
108 S. Elwood Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Anastasia Andreadakis
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 5 dat

8. AGE: Years | Months | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Gus Andreadakis
13. Birthplace Bethlehem Penna

MOTHER 14. Maiden Name Betty Zudas
15. Birthplace Steubenville Ohio

16 (a) Informant Gus Andreadakis
(b) Address 108 S. Elwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 6 1947 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox
Location Baltimore - Md

18 (a) Funeral director Howard E. Covington
(b) Address 211 N. 25th St Phone

19 (Filed) FEB 6 1947 Huntington Williams M.D.

VS 180

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3 Feb 47 1947, at 11:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1 Feb 1947 to 3 Feb 1947, and that I last saw her alive on 3 Feb 1947

Immediate cause of death Intracranial Hemorrhage — Duration

Due to Birth Injury

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John H. Sonntag M.D.
Address Franklin Sq Hosp Date signed 2/7/47

PHYSICIAN
Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

AB-2015 G48288

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 30a

Registered G48288

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address: 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days): 12yrs- 9mos.- 19days

(e) Length of stay in Baltimore (yrs., mos., or days): 42 yrs.

**2. USUAL RESIDENCE OF DECEASED:**

(a) State: Md. (b) County:

(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No.: 1203 N. Gay St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country:

**3 (a) FULL NAME:** Helen Vulgaris

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Thomas (D

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ?-?- 1872?or1873?

8. AGE: Years: 74? or 75? Months: ? Days: ? If less than one day: hr. min.

9. Birthplace: Greece (Town, county, and state)

10. Usual Occupation:

11. Industry or business:

FATHER 12. Name: ?

13. Birthplace: ?

MOTHER 14. Maiden Name: ?

15. Birthplace: ?

16 (a) Informant: Records -Baltimore City Hospitals

(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 6 1947 (month) (day) (year)

(c) Cemetery or crematory: Greek Orthodox

Location: Baltimore - Md.

18 (a) Funeral director: Leonard Covington

(b) Address: 21 W. 20th ST.

19 (a) (Date rec'd by registrar) (b)

VS 150 FEB 6 - 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 3- 1947, at 5.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-14- 1934 to 2-3- 1947, and that I last saw h- er alive on 2-3- 1947.

| | Duration |
|---|---|
| Immediate cause of death: Resp. Failure | |
| Due to: Hypertensive C-V Disease. | |
| Due to: | |
| Other Conditions: Tabes Dorsalis. Hypertrophic Arteritis of Senile (Include pregnancy within 3 months of death) | |
| Date of operation: | |
| Major findings of operation: | |
| of autopsy: | |

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature: Herbert R. Forbes M. D.

Address: Balto. City Hosp. Date signed: 2-3-47

X

G18289

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 95c

G18289 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1224 Carlton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 Carlton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Louise Barber Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Bennie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 50 | Months 49 | Days | If less than one day hr. min.

9. Birthplace md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Tom Brayne
13. Birthplace md

MOTHER
14. Maiden Name Unobtainable
15. Birthplace

16 (a) Informant Jennie Carter
(b) Address 1329 Whatcoat St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Mrs. H. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) FEB 6 — 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 4 1947, at 1 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to Feb 4 1947 and that I last saw her alive on Jan 1947.

Immediate cause of death: Myocardial failure — Duration 1y 7m
Due to: Hypertrophy and dilation of heart
Due to:
Other Conditions: None
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. H. Pendleton M.D.
Address 1723 Druid Hill Ave Date signed 2/4/47 M. D.

VS 150

G48290 BC# G36207 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH ✓ 38E G48290 Registered No. (new)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital 16 ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 914 N. Arlington
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME Melvin Sneed ✓

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 3, 1945

8. AGE: Years 1 | Months 3 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Louis Sneed
13. Birthplace North Carolina

MOTHER
14. Maiden Name Brittan Thompson
15. Birthplace Virginia

16 (a) Informant Mother
(b) Address 914 N. Arlington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. S. Kelson
(b) Address 1303 Pennsylvania Ave

19 (Filed) FEB 6 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 4, 1947 at 9 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-26- 1947 to 2-4- 1947, and that I last saw him alive on 2-4- 1947.

| | Duration |
|---|---|
| Immediate cause of death: asphyxia | 20 min |
| Due to: tracheal obstruction | 20 min |
| Due to: | |
| Other Conditions: Heart failure, etiology unknown (Include pregnancy within 3 months of death) | 10 mo |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Peggy Renee Hamlin
Address Sydenham Hospital Date signed M 2/4/47 D

V S 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G18291

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G18291 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto. Co.
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 7413 Beach Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Frank Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-8929

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Black | Married |

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-15-00

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | 8 | 26 | hr. min. |

9. Birthplace Texas (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Rebecca ?
15. Birthplace Texas

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL 2/8/47

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A A Co. Md

18 (a) Funeral director Robert E. Wilkinson
(b) Address 15-15 McElderry St

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 6 - 1947
Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 1 1947 at 12:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19 1947 to Feb 1 1947 and that I last saw him alive on Feb 1 1947.

| Immediate cause of death | Duration |
|---|---|
| Coma | |
| Due to Syphilis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at P.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. H. Dubois M. D.
Address Johns Hopkins Hospital Date signed 2-7-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18292

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G18292 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1214 Eutaw Place
(c) Hospital or institution: Baltimore Eye Ear Th't Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs, 10 minutes
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3905 Melton Road
(If rural give location)
Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Harris Goldman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Catherine Goldman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years 46 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Tavern Owner

11. Industry or business

FATHER 12. Name Michael Goldman

13. Birthplace Russia

MOTHER 14. Maiden Name Fannie Silverman

15. Birthplace Russia

16 (a) Informant Hospital Record

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-47 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 1409 E Baltimore St

19 (a) Filed Feb 6 - 1947 Huntington Williams M.D. Registrar (Date received by registrar)

VS 8

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1947, at 7:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 5 1947, to Feb 5 1947, and that I last saw him alive on Feb 5 1947

Immediate cause of death: CORONARY THROMBOSIS — Duration: 45 MIN.

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: HAD NASAL POLYPECTOMY AT 1:00 PM. FEB 5 '47

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Steiner M. D.

Address Balto Eye Ear & Throat Hosp. Date signed Feb 5 1947

G48293

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G48293 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4407 LIBERTY HEIGHTS
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28-2
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yr

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4407 LIBERTY HEIGHTS
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Abraham Williams

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Fannie
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1878
8. AGE: Years 69 | Months | Days | If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Worn
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Rose
15. Birthplace Russia

16 (a) Informant M. Williams
(b) Address 4407 Liberty Heights Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-47 (month) (day) (year)
(c) Cemetery or crematory Chevra Yakov
Location Pikesville Run Cem.
18 (a) Funeral director Jack Levin Sons
(b) Address 1432 E. Baltimore St
19 (a) Registered by (b) Huntington Williams M.D.
FEB 6 1947
VS-150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/5 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1938 to 2/5 1947
and that I last saw him alive on January 5, 1946

Immediate cause of death: Arteriosclerotic Cardio-Vascular Disease — Duration: few years
Due to
Due to
Other Conditions: Coronary Sclerosis — Duration: one year
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. A. Grossman M. D.
Address 1107 N. Calvert St. Date signed 2/8/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48294

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G48294 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Pall Mall Rd + Wylie Ave
(c) Hospital or institution:
Jewish Convalescan Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County Baltimore
(c) City or town ~~2317 Whittier Ave~~
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2317 Whittier Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Goldfuss

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Laib
13. Birthplace Russia

MOTHER
14. Maiden Name Libby
15. Birthplace Russia

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-47 (month) (day) (year)
(c) Cemetery or crematory Shaarei Tfiloh
Location Windsor Mill Rd.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto. St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

FEB 6 1947

VS 15d

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 5 1947 at 11:9 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1932 to Feb 4 1947, and that I last saw h.e. alive on Feb 3 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary occlusion | Sudden |
| Due to Hypertension | 15 yrs |
| Due to Arterio Sclerosis | 8 yrs |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1720 Eutaw Pl Date signed 2/5/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48295 — BALTIMORE CITY HEALTH DEPARTMENT — G48295 Registered No.

# CERTIFICATE OF DEATH 83a

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Rayner Ave. & Dukeland St.
(c) Hospital or institution West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) -

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3403 Dolfield Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mrs. Sarah C. Hankin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife William Hankin
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 6, 1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 7 | - | hr. min. |

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Max Tenner
13. Birthplace Russia

MOTHER
14. Maiden Name Katig
15. Birthplace Russia

16 (a) Informant: Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phot Rd.
18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St
19 (a) (Date rec'd by registrar) (b) Huntington Williams

FEB 6 - 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6, 1947 at 4:10 AM
21. I certify that death occurred on the date above stated; that I attended deceased from Feb 5, 1947 to Feb 6, 1947 and that I last saw h[illegible] alive on Feb 6, 1947

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Cerebral hemorrhage Lt. | |
| Due to Hypertension | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Leon Toby M.D.
Address West Balto. Gen. Hosp. Date signed 2/6/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48296

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G48296

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd & CALVERT
(c) Hospital or institution: Union Memorial Hosp. 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 218 LAURENS ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME THOMAS DAVIDSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife HELEN RAY DAVIDSON
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 14 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 2 | 21 | 20 hr. min. |

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation CIVIL ENGINEER
11. Industry or business

FATHER
12. Name Benjamin Davidson
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Iglehart
15. Birthplace Maryland

16 (a) Informant wife
(b) Address 218 Laurens St Balt.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mount Olivet
Location Baltimore, Md.

18 (a) Funeral director H. W. Meares and Son
(b) Address 805 N. Calvert St.

19 (a) FEB 6 1947 (Date received by Registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 1947; at 2:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1947 to Feb 4 1947 and that I last saw h.... alive on Feb 4 1947

| Immediate cause of death | Duration |
|---|---|
| Shock | |
| Due to hemorrhage - post operation | 1 day |
| Due to hemorrhoidectomy | |
| Other Conditions Asthma → 50 years; Arteriosclerotic Heart Disease → 7 years | |

(Include pregnancy within 3 months of death)

Date of operation Feb 3, 1947
Major findings of operation: Thrombosed hemorrhoid, rectal polyp.
of autopsy: 40% of blood in rectum

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph C. Pretti, M. D.
Address Union Mem. Hosp. Date signed 2-4-47

Huntington Williams, M.D.

VS 150

X

G48297

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 91a

G48297 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 902 N. Marris st. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Richard Louis Blick

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-22-5079

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1926

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 21 | | | hr. min. |

9. Birthplace Lawrenceville Virginia (Town, county, and state)

10. Usual Occupation Butler

11. Industry or business Public

FATHER
12. Name Thomas Blick
13. Birthplace Virginia

MOTHER
14. Maiden Name Lillian Vaughn Taylor
15. Birthplace Virginia

16 (a) Informant Lillian Vaughn Taylor
(b) Address 902 Morris stret

17 (a) (Burial, cremation, or removal) (b) Date thereof 3 6 47 (month) (day) (year)
(c) Cemetery or crematory Aberta
Location Aberta Virginia

18 (a) Funeral director Baltet Bros
(b) Address 918 Druid Hill

19 (a) Filed by registrar FEB 6 1947 (b) Registrar Huntington Williams M.D.

VS 191

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/2 1947, at 8 30 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry), find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subacute bacterial endocarditis

Due to

Other Conditions Pulmonary edema & congestion
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Homer J. Mullen Medical Examiner. M.D.
Date signed 2-4-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48298

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 47c

Registered No. G48298

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Oliver + Caroline St.
(c) Hospital or institution: St. Josephs Hospital 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 E. Hamburg Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Leonard Wilson Rowe

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-16-1101

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Regina K.
6 (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) 10/15/90

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 3 | 21 | hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Guard
11. Industry or business Morgue Guard.

FATHER
12. Name Chas Rowe
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Anna M. Fickler
15. Birthplace Baltimore Md

16 (a) Informant Mrs L. B. Rowe
(b) Address 108 E Hamburg St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location Ritchie Highway

18 (a) Funeral director J. J. Lobb & Sons
(b) Address 23 S. Light St.

19 (a) (Signature of registrar) (b) (Registrar's number)

FEB 6 - 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/5/1947 at 1:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/8 1947 to 2/5 1947; and that I last saw h. l. alive on 2/5/1947

| Immediate cause of death | Duration |
|---|---|
| Cardio Respiratory Failure | |
| Due to Pleural Effusion | |
| Due to Bronchogenic Carcinoma | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
to examination
of autopsy Carcinoma left hilus & extension ↑

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard A. Young M.D.
Address St. Josephs Hosp Date signed 2/5/47

X

G48299

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered G48299

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3907 Carlisle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3907 Carlisle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: LILLIAN M. PLUMB

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife: Elza A. Plumb
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 1 | 10 | hr. min. |

9. Birthplace Carroll Co., Md.
(Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name Christian A. Gunther
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Annie Giggard
15. Birthplace Harford Co., Md.

16 (a) Informant Mrs. Elsa A. Plumb
(b) Address 3907 Carlisle Ave.

17 (a) Burial (b) Date thereof 2/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Leisters Cem.
Location near Westminster, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Williamsport, Md.
(Date rec'd by) Registrar

FEB 6 - 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4, 1947 at 2:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw her alive on 2/4 1947

Immediate cause of death: Uraemia

Due to: Hypertension

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: 8 days / 2 days

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature Henry Cassell
Address 3902 Groveland Ave. Date signed 2/8/47

15 X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48300 / 131a

Registered No. G48300

G48300

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 326 St. Dunstans Rd.
(c) Hospital or institution:

27-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 326 St. Dunstans Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** JOHN AARON MacDONALD

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 217-14-1117

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary MacDonald
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1885

8. AGE: Years 61 | Months 9 | Days 3 | If less than one day hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation Teller
11. Industry or business Bank Business

FATHER
12. Name Paterson Hayes MacDonald
13. Birthplace -

MOTHER
14. Maiden Name Lou Emma Marshall
15. Birthplace -

16 (a) Informant Mrs. John A. MacDonald
(b) Address 326 St. Dunstans Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/6/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

FEB 6 - 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 4, 1947 at 4:50a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1947, to Feb 4 1947 and that I last saw him alive on 2-4 1947.

Immediate cause of death: Uremia — Duration: 1 week
Due to: Cardio-renal Vascular Disease
Due to: Hypertension and Chronic nephritis
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Emma F. Hood M. D.
Address 240 Garrison Blvd Balto. Md. Date signed 2-5-47

X

G48301

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

108

G48301 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1807 E. Federal Street
(c) Hospital or institution:

8 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 E. Federal Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS DUNCAN KERR

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louise Stroemer
6 (c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): June 21, 1869

8. AGE: Years: 77 | Months: 7 | Days: 13 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: ELECTRICAL, Ret. 13yr.
11. Industry or business: Gas & Elec. Co.

FATHER
12. Name: Francis Kerr
13. Birthplace: Maryland

MOTHER
14. Maiden Name: ? MacCauley
15. Birthplace: Maryland

16 (a) Informant: Mrs. Louise Kerr
(b) Address: 1807 E. Federal Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-6-47 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) Rec'd by registrar 1947 (b) Registrar

VS 150

## MEDICAL CERTIFICATION

PM

20. DATE OF DEATH Feb. 3, 1947, at 8.33 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 8 1944, to Feb 3 1947, and that I last saw h[illegible] alive on Feb [illegible] 1947.

| Immediate cause of death | Duration |
|---|---|
| Acute Cardiac Failure | 1 Day |
| Due to Lobar Pneumonia (Left) | 1 Week |
| Due to Infection | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Michael A. Abrams M. D.
Address 1806 Eutaw Place Date signed 2-4-47

X

G48302

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48302 Registered No. 122a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts
(c) Hospital or institution St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4615 Kavon Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Ruby B Jessop

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widow |

6 (b) Name of husband or wife Clinton Jessop
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 8 | 23 | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas J. Boram
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Welsh
15. Birthplace Conn.

16 (a) Informant Mr. Clinton J. Boram
(b) Address 4615 Kavon Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/47 (month) (day) (year)
(c) Cemetery or crematory Sherwood Ch. Cem.
Location COCKEYSVILLE, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b) Registrar
FEB 6 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 5 1947 at 6 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 30 1947 to Feb 5 1947 and that I last saw h&R alive on Feb 5 1947

| Immediate cause of death | Duration |
|---|---|
| Peritonitis | |
| Due to opening of Anastomosis | |
| Due to Gangrene of Bowel | |
| Other Conditions Diverticulosis Hernia Gall Stone | |

(Include pregnancy within 3 months of death)
Date of operation Feb 1, 1947
Major findings of operation: Gangrene of Bowel
of autopsy: Peritonitis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas F. Wilson, Jr. M.D.
Address St. Joseph's Hosp Date signed 5 Feb 47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48303

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93E

G48303 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2 Hillbrook Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 Yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Hillbrook Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** KATHARINE L. BROENING

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Single |

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/15/1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 7 | 19 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER
12. Name Jacob Broening
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Lyne
15. Birthplace Maryland

16 (a) Informant Mary L. Broening
(b) Address 2 Hillbrook Rd

17 (a) Burial (b) Date thereof 2/7/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Old Frederick Rd

18 (a) Funeral director Edward Taylor Sons
(b) Address 318 Light St

19 (a) (b) Huntington Williams, M.D.
(Date received by registrar)

FEB 6 - 1947

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 2/4 1947. 8:40 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 5/29 1939, to 2/4 1947. and that I last saw h[illegible] alive on Feb 4 1947.

Immediate cause of death Myocarditis —

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature Charles R. Gardner M. D.

Address 2923 St Paul St Date signed 2/5/47

G48304

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 124 B

G48304 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Rayner Ave. & Dukeland St.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 807 Scott St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Arthur Langrath

3 (b) If veteran, name war WW
3 (c) Social Security Account No. 215-09-6773

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1913

8. AGE: Years 33 | Months 7 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Transportation Solicitor
11. Industry or business Transportation

FATHER 12. Name Charles Langrath
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Hattie Hahn
15. Birthplace Balto. Md.

16 (a) Informant Alfred Langrath
(b) Address 807 Scott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-8-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave.

18 (a) Funeral director Danbrook Bros.
(b) Address 464 N. Franklintown Rd.

FEB 6 1947 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 190

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5, 1947 at 10:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 28, 1947 to Feb. 5, 1947 and that I last saw him alive on Feb. 5, 1947

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure and Uremic insufficiency | |
| Due to Hepatic necrosis (Portal cirrhosis) | |
| Due to | |
| Other Conditions Terminal uremia and pulmonary edema (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leon Toby M.D.
Address West Balto. Gen. Hosp. Date signed 2/6/47

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The
PLEASE WRITE PLAINLY, WITH UNFADING INK. Erase write the causes of death clearly and legibly.
correct age is especially important. Physicians: please

G48305

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 1947

G48305 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd St.
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 61 year

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 929 N. CALVERT ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE J. WEBER.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | S |

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) OCT. 18, 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 62 | 4 3 | 18 | hr. min. |

9. Birthplace OHIO (Town, county, and state)
10. Usual Occupation PAINTER.
11. Industry or business —

FATHER 12. Name FRED WEBER
13. Birthplace SWITZERLAND.

MOTHER 14. Maiden Name MARY VALERY
15. Birthplace GERMANY.

16 (a) Informant —
(b) Address

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 2/6/47 (month) (day) (year)
(c) Cemetery or crematory Toledo
Location Toledo Ohio

18 (a) Funeral director Wilhoun & Son Inc
(b) Address 1219 ft Tool St

19 (a) FEB 6 1947 (b) Registrar
(Rec'd by registrar)
Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH FEB. 5 1947, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from JAN. 27, 1947 to FEB. 5 1947, and that I last saw HIM alive on FEB. 5 1947.

| Immediate cause of death | Duration |
|---|---|
| UREMIA | 5 d. |
| Due to HYPERTENSIVE CARDIOVASCULAR DISEASE. | 5 YR. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy NONE

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Crawford N. Kilpatrick Jr. M.D.
Address Union Memorial Hosp. Date signed 2/5/47

X

G48306

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

99

G48306 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. Balto, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Chase
(If outside city or town limits, write RURAL and give town)
(d) Street No. Bird River Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry H. Hillen

3 (b) If veteran, name war

3 (c) Social Security Account No. none

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Florence M. Hillen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 4 | 22 | hr. min. |

9. Birthplace Balto. Co., Md.
(Town, county, and state)
10. Usual Occupation Truck Farmer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Harry H. Hillen
(b) Address Bird River Rd. Balto. 20, Md.

17 (a) burial (b) Date thereof Feb. 8, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Zion Lutheran
Location Stemmers Run, Md.

18 (a) Funeral director Leo A. Rehn Funeral Home
(b) Address 7401 Belair Road

19 (a) [illegible] (b) Huntington Williams M.D.
(Date received by registrar) Registrar

FEB 6 1947

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 5th 1947 at 10 16 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30 1947 to Feb 5 1947 and that I last saw him alive on Feb 5 1947

Immediate cause of death retroperitoneal hemorrhage — Duration

Due to rupture of left iliac artery

Due to arteriosclerosis + atheromatosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Not obtained

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold M. Jacobs M. D.
Address Sinai Hosp. Date signed 2/5/47

X

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48307 BC# G11316 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH X 106c G48307 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hosp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 1 S. Beechwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Richard Griffin
3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 22. 1944
8. AGE: Years 2 Months 3 Days 13 If less than one day hr. min.
9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business
FATHER 12. Name James W. Griffin
13. Birthplace Balto Md
MOTHER 14. Maiden Name Doris R. Roper
15. Birthplace Balto Md
16 (a) Informant James W. Griffin
(b) Address 1 S. Beechwood Road, Catonsville
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 7. 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.
18 (a) Funeral director Mc Mus John W. Geisel & Son
(b) Address 5311 Edmondson Ave
19 (a) FEB 6 1947 (Date received by registrar) (b) Huntington Williams, Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 4 1947, at 5 45 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1947, to Feb 4 1947 and that I last saw him alive on Feb 4 1947

| Immediate cause of death | Duration |
|---|---|
| Respiratory Obstruction | |
| Due to Laryngo-Tracheal Neoplasm | 2 Days |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Robert E. Fowler M. D.
Address Bon Secours Hosp, Balto Date signed 2-4-47

VS 190

X

G48208 BGH G48208

BALTIMORE CITY HEALTH DEPARTMENT

AB-107548 G67727 CERTIFICATE OF DEATH 1119a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 6-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 37 N. Belnord Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy-Warren (John M. WARREN) ✓

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13-1947

8. AGE: Years | Months | Days: 23 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Marian M. Warren
13. Birthplace N.C.

MOTHER
14. Maiden Name Anna Mae Wakefield
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospit
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 7/47 (month) (day) (year)
(c) Cemetery or crematory Bald Lens
Location Bald Md

18 (a) Funeral director Philip Hiram Sons
(b) Address 2024 Allens Ave

19 (a) (b) (Date received by registrar) Registrar

EB 6 1947

VS 150

Huntington Williamsville, Md

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 6- 1947, at 6.50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-13- 1947 to 2-6- 1947 and that I last saw him alive on 2- 6- 1947

| Immediate cause of death | Duration |
|---|---|
| Diarrhea | Unk. |
| Due to Prematurity | life |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hooper

Address Balto City Hosp Date signed Feb. 6 '47 (M. D.)

X

AB-106181 G48309

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1382

Registered No. G48309

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address: 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 18-2

(d) Length of stay in hospital or inst. (yrs., mos., or days): 2mos- 16days

(e) Length of stay in Baltimore (yrs., mos., or days): Life

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md. (b) County Baltimore

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 1014 Edmondson Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Gussie Gualman (Gaulman)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife: David

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29- 1925

8. AGE: Years 21 | Months 5 | Days 5 | If less than one day ____hr. ____min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name George Phillips

13. Birthplace Maryland

MOTHER

14. Maiden Name Gussie Phillips

15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-47 (month) (day) (year)

(c) Cemetery or crematory Balto. Natl. Location 5500 Frederick Ave.

18 (a) Funeral director Charles L. Law

(b) Address 602 Madison Ave.

19 (a) ____ (Date received by registrar) (b) ____ Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4- 1947 at 3.10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-18- 1946 to 2-4- 1947 and that I last saw her alive on 2-4- 1947

Immediate cause of death: Carcinomatosis, Pelvis, Advanced — Duration 6 mos.

Due to: ____

Due to: ____

Other Conditions: ____

(Include pregnancy within 3 months of death)

Date of operation: ____

Major findings of operation: ____

of autopsy: Refused

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide: ____

(b) Date of occurrence: ____ at ____ M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? ____

(e) Means of injury: ____

23. Signature W. J. Hunt M. D.

Address Feb. 4 1947 Date signed

VS 150

Huntington Williams, M.D. Balt. City Hosp.

G48310 BC# G42115 BALTIMORE CITY HEALTH DEPARTMENT ✓119a G48310

# CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 417 Fawcett St.
(c) Hospital or institution:

12-7

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 417 Fawcett St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Woodrow R. Gill ✓

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|

| 4. Sex | 5. Color or race | 6 (a) Single, ~~married, widowed~~, or ~~divorced~~ |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16-1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 11 | 20 | hr. min. |

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Randolph Reuben Gill
13. Birthplace Lancaster Pa

MOTHER
14. Maiden Name Muriel Willemore
15. Birthplace Walnut St Pa

16 (a) Informant Randolph R. Gill
(b) Address 417 Fawcett St

17 (a) Removal (b) Date thereof Feb 7-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Family Grave Yard
Location Lancaster Lancaster Co Pa

18 (a) Funeral director Batsons Sons
(b) Address 2234 N Charles St

19 (a) (b)
(Date received by registrar) Registrar

VS 181 FEB 6 - 1947 Huntingtown Millersville Md

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 6, 1947, at 8.50 A M

21. I certify that I took charge of the remains described above, held an Autopsy, thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Infantile enteritis.
Mesenteric lymphadenitis.
Due to Congestion and edema of brain.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 2-6-47

X

G48311

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH √ 93D

G48311 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) dec'd
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5217 Beaufort ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lewis E. RUPPERT

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-9261

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Leona R.

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) 2-7-1869

8. AGE: Years 77 | Months 11 | Days 28 | If less than one day ____hr. ____min.

9. Birthplace Baltimore County, Md. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Wm. Ruppert
13. Birthplace Germany

MOTHER
14. Maiden Name Mary C. Steigel
15. Birthplace U.S.

16 (a) Informant Mrs. Lewis E. Ruppert
(b) Address 5217 Beaufort Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 8 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Randallstown, Md.

18 (a) Funeral director E. Wilkes Lawrence
(b) Address 4516 Liberty Hgts Ave.

19 (a) FEB 6 1947 (Registered by) (b) Huntington Williams M.D.

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5th 1947 at 4 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 2/6/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48312

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. G48312

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: So. Balto Gen Hosp. 18

(d) Length of stay in hospital or inst. (~~year, month~~ days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 131 Parkin St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country Russia

3 (a) FULL NAME Ewdokim Kuresha (EWDOKM KURESHA)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | S |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not known

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 | 6 | 27 | hr. min. |

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Kalistrat Kuresha
13. Birthplace Russia

MOTHER
14. Maiden Name Anna ?
15. Birthplace Russia

16 (a) Informant Mrs. Averky Kuresha
(b) Address 650 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-47 (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russian
Location Stevens Road B. & O. Co.

18 (a) Funeral director Joseph A. Greblunaskas Jr
(b) Address 1023 S. Paca St.

19 (a) (Date rec'd by Registrar) 1947 Curtis Williams M.D. (Registrar)

FEB 6

VS 15

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 5 1947 at 5:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1947, to Feb 5 1947, and that I last saw h. ~~m~~ alive on Feb 5 1947.

Immediate cause of death Cerebral Hemorrhage — Duration Cerebral Hemorrhage
Due to Hypertensia
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J O Carrickson
Address So. Balto. Gen Hosp Date signed 2/5/47 (M. D.)

X

G48313

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48313 Registered No. 1310

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2108 N. Howard
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2108 N. Howard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ulysses Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Col. | Married |

6 (b) Name of husband or wife Mamie Moore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1917

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 29 | 10 | 10 | hr. min. |

9. Birthplace Aiken S. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Jefferson Moore
13. Birthplace Edgefield S.C.

MOTHER
14. Maiden Name Lidia Mackie
15. Birthplace Edgefield

16 (a) Informant Clorbella Thomas
(b) Address 2108 N. Howard St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Feb. 6, 1947 (month) (day) (year)
(c) Cemetery or crematory Augusta Ga.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 922 N. Schroeder St.

19 (a) (Signature of local registrar) (b) Huntington Williams, M.D.

FEB 6 1947

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb 4 1947, at 5 P M

**21.** I certify that death occurred on the date above stated, that I attended deceased from Jan 29 1947, to Feb 4 1947, and that I last saw him alive on Feb 3 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardiac Renal Disease | 1 yr. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Luis A Johnson M.D.
Address 2829 Guilford Ave Date signed Feb 7 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18314

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

107

G18314 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address CALVERT AND SARATOGA
(c) Hospital or institution:
MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County —
(c) City or town BALT.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 CATHEDRAL ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MRS MARY M GARDNER.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | MARRIED |

6 (b) Name of husband or wife DR. WM. S GARDNER.
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) OCT. 15, 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 3 | 22 | hr. min. |

9. Birthplace MD. Kent Co
(Town, county, and state)
10. Usual Occupation HOUSEWIFE.
11. Industry or business

FATHER
12. Name (CHARLES) MASLIN
13. Birthplace MD. Kent Co.

MOTHER
14. Maiden Name HANNAH BALL
15. Birthplace MD. DEL.

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (b) Date thereof FEB 8 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem
Location Pikesville Md

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address McCulloh & Orchard Sts.

FEB 6 1947 (a) (b) Washington Williams, M.D. Registrar
(Date rec'd by)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH FEB 6 1947, at 2:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from FEB 2 1947 to FEB 6 1947, and that I last saw h.E.K. alive on FEB 6 1947

| | Duration |
|---|---|
| Immediate cause of death RESPIRATORY FAILURE. | |
| Due to BRONCHOPNEUMONIA. | |
| Due to CONGESTIVE HEART FAILURE. | |
| Other Conditions POSSIBLE CORONARY THROMBOSIS | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James A. Roberts M. D.
Address Mercy Hospital. Date signed 2-6-47

X

G18315 C.C. 9.64935

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

159

G18315 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 876 Washington Blvd.
(c) Hospital or institution: Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 524 N. Streeper St. #5 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Baby Girl Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | white | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 5th 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 1 | hr. min. |

9. Birthplace Doctors Hospital Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Emory Clayton Bell
13. Birthplace Rome, Georgia

MOTHER
14. Maiden Name Elaine Thelma Sommerman
15. Birthplace Baltimore, Maryland

16 (a) Informant Emory Bell
(b) Address 524 N. Streeper St

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/7/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cedar Hill
Location A.A. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 129 St. Paul St.

19 (a) Date received by Registrar FEB 7 1947 (b) Registrar Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb. 6 1947 at 7 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Feb. 5 1947 to Feb 6 1947, and that I last saw him alive on Feb 6 1947.

Immediate cause of death Acute Cardiac Failure — Duration 1/2 hours

Due to

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Israel Rosen M. D.
Address 2413 E Monument St Date signed

X 2/7/47

G48316

AB-98363

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13B

G48316

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitlas

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr- 4mos- 7days
(e) Length of stay in Baltimore (yrs., mos., or days) 16yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 E. Biddle Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Cipris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5-1907

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 37 | 10 | 2 | hr. min. |

9. Birthplace England
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Micheal O'Hare
13. Birthplace Ireland

MOTHER
14. Maiden Name Agnes Flower
15. Birthplace England

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 2/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

FEB 7 - 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 6- 1947, at 9:45AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29 1945, to 2-6- 1947 and that I last saw her alive on 2-6- 1947

Immediate cause of death: Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. E. Drabler M. D.
Address Baltimore City Hospital Date signed 2-6-47

VS 150

X

G18317 BC# G6975 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G18317

# CERTIFICATE OF DEATH 159

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to state the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:** Baltimore
(a) State Md. (b) Seversden et
(c) City or town Baltimore Leonard St (If outside city or town limits write Rural and give town)
(d) Street No. 535 Leonard St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

**3 (a) FULL NAME** Baby Girl Eddy
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Single |

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/2/47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | 17 hr. min. |

9. Birthplace Baltimore MD (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER — 12. Name Neal Alexander Eddy
13. Birthplace Balt MD

MOTHER — 14. Maiden Name Elizabeth Emerson
15. Birthplace Balt MD

16 (a) Informant Elizabeth Eddy
(b) Address Balto MD

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School FEB 6 1947

18 (a) Funeral director Commissioner of Health
(b) Address
19 (Date rec'd by registrar) FEB 6 1947 Huntington Williams M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/3 1947, at 7:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/2 1947 to 2/3 1947, and that I last saw Chd. alive on 2/3 1947

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions Bilateral atelectasis
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Spellman M. D.
Address Univ Hosp Date signed 2/3/47

G18318 P.C.J. 68964

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

G18318 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give name)
(d) Street No. 409 S. Pulaski St. Univ. Hosp. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Girl Collins

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Single |

6 (b) Name of husband or wife None

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2-4-47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 0 | 0 | 0 | 3 hr. 49 min. |

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name James E. Collins
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Ruth Stricker
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Ruth Collins
(b) Address 409 S Pulaski St. Baltimore, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory University Medical School
Location FEB 6 1947

18 (a) Funeral director Commissioner of Health
(b) Address

FEB 6 1947 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 2-4 1947, at 3:20 P.M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2-4 1947, to 2-4 1947, and that I last saw her alive on 2-4 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardio Respiratory Failure | |
| Due to Prematurity | |
| Due to | |
| Other Conditions Chondro-dystrophy | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roger H. Black M.D.

Address University Hosp. Date signed 2-4-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48319

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

119a

G48319
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (~~year, month~~, or days) 15
(e) Length of stay in Baltimore (~~year, month~~, or days) 16

**2. USUAL RESIDENCE OF DECEASED:**
(a) State VIRGINIA (b) County
(c) City or town BRISTOL
(If outside city or town limits, write RURAL and give town)
(d) Street No. 420 PARK ST (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARGARET RIDGWAY DAVIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | S |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5 / 11 / 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 0 | 8 | 26 | hr. min. |

9. Birthplace BRISTOL VIRGINIA
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name NORRID S DAVIS
13. Birthplace TENNESSEE

MOTHER
14. Maiden Name MARGARET STEARNS
15. Birthplace NEW YORK

16 (a) Informant HOSPITAL RECORDS
(b) Address

17 (a) Removal (b) Date thereof 2 7 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Gloucester Va.

18 (a) Funeral director Philip Hurley Sons
(b) Address 2028 Eutaw St.

19 (a) FEB 7 1947 (b) Huntington Williams, M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 7 1947; at 5:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1947 to Feb 7 1947, and that I last saw her alive on 7 Feb 1947

| Immediate cause of death | Duration |
|---|---|
| Pneumonia | |
| Due to Septicemia | |
| Due to | |
| Other Conditions diarrhea | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene B Chambers M. D.
Address 35a Cabot St 24a Balt Md Date signed 7 Feb 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48320

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46E

Registered No. G48320

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3624 Fairview Ave.
(c) Hospital or institution: none

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3624 Fairview Ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** Rosaria Serio

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widowed |

6 (b) Name of husband or wife Frank Serio
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 5 | 6 | hr. min. |

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Santo Forte
13. Birthplace Italy

MOTHER
14. Maiden Name Catharine Giardina
15. Birthplace Italy

16 (a) Informant Catherine Serio
(b) Address 3624 Fairview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-8-47 (month) (day) (year)
(c) Cemetery ~~Old Cathedral~~ New Cathedral
Location Edmondson Ave., Baltimore

18 (a) Funeral director John O. Mitchell & Son
(b) Address 1900 Eutaw Place

19 (a) (b) Registrar
(Date received by registrar)

FEB 7 1947 Burdette G. Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1-1945 to 2-5-1947 and that I last saw h~~im~~er alive on 2-4-1947

Immediate cause of death Respiratory paralysis. — Duration 4 yrs

Due to pressure on brain of Pituitary tumor. — 2 mo

Due to carcinoma of sigmoid. — 3yr?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. J. Smalley M. D.
Address Medical Arts Bldg. Date signed

X

G48321

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 178a

G48321 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County 10
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 538 Chateau Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Curtis R. Chittenden

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Rose E. Chittenden (Nee Krach) 6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) May 12, 1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | 8 | 23 | ____hr. ____min. |

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation B. & O. R.R. Yardmaster
11. Industry or business at Curtis Bay Yard

FATHER
12. Name Ransom C. Chittenden
13. Birthplace Michigan

MOTHER
14. Maiden Name Elizabeth R. Greedy
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Rose E. Chittenden (wife)
(b) Address 538 Chateau Ave. (Balto. R, Md.)

17 (a) Burial — (b) Date thereof Feb. 8, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Baltimore, Md.

18 (a) Funeral director A. B. Edward Evans
(b) Address 1408 Charles St. Balto. 3, Md.

19 (a) FEB 7 - 1947 (b) Huntington Williamsville, Md.
(Date rec'd by registrar)

VS 181

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 1947, at 11:36 P M

21. I certify that I took charge of the remains described above, held an Autopsy & Inquest thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ Robbery, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to illuminating gas
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-5-47 at (?) 10 a. M.
(b) Where did injury occur? 538 Chateau Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Illuminating gas Robbery suspect and gas range

23. Signature Howard J. Weedon M.D.
Medical Examiner.
Date signed 2-5-47

G48322

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13B

Registered No. G48322

AB.-107998

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 N. Broadway
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Warren Cole (Warren E. Cole Sr.)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 218-01-7285

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widower |

6 (b) Name of husband or wife Gertrude A. Heaphy
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Jan. 28- 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 0 | 7 | ....hr. ....min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Painter & Maintenance Man
11. Industry or business Bank Building

FATHER
12. Name Louis Cole (D
13. Birthplace Va.

MOTHER
14. Maiden Name Alice Hodge or Doges (D
15. Birthplace Mass.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) FEB 7 - 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5- 19 47, at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-28- 19 47 to 2-5- 19 47, and that I last saw h im alive on 2-5- 19 47.

| Immediate cause of death | Duration |
|---|---|
| Respiratory Faelure | |
| Due to Pulmonary Tuberculosis | |
| & Pulmonary Tuberculosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Causes above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm R. Fearnaught M. D.
Address Balto City Hosp Date signed 2-6-47

G48323

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G48323 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1932- E. Lombard St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** LOUIS J. BACH (Aloysius John Bach)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 216-03-3920

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret A. Pfeifer

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) April 17, 1883

8. AGE: Years 63 | Months 9 | Days 20 | If less than one day ######## min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Paymaster (Asst.)

11. Industry or business Copper & Brass Works

FATHER
12. Name Adam J. Bach
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Schmidt
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Rosalie Prosser
(b) Address 100 S. Wolfe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

FEB 7 - 1947 (Date rec'd by Reg.) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 6, 1947, at 8.50 A M

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-Vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Weeks M.D. Medical Examiner.
Date signed 2-6-47

VS 131

BC#D 69164
D. Bur. 648324

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1579

Registered No. 648324

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital 9-B
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6Days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore - 11,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 E. 29th. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Carole Ann MacKenzie

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F. | W. | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/30/47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 6 | hr. 55 min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Stuart Arthur MacKenzie
13. Birthplace Darluth Minnesota

MOTHER
14. Maiden Name Maria Christine Totaro
15. Birthplace Baltimore Maryland

16 (a) Informant Stuart A. MacKenzie
(b) Address 170? E. 29th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cemetery
Location Prince Georges County

18 (a) Funeral director Elizabeth Funeral Home.
(b) Address 115 E. West St.

19 (a) (Date rec'd by registrar) (b) Register 1947

VS 190 Huntington-Williams, Md. FEB 7

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/5/47 19 11:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30 1947 to Feb 6 1947 and that I last saw him alive on Feb 6 1947

Immediate cause of death Congenital stenosis of Pylorus and duodenum

Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Feb 6, 1947

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature H. D. Salerno M. D.
Address Bon Secours Hosp. Date signed 2-6-47

X

G48325

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1946

Registered No. G48325

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2117 Denison St.
(c) Hospital or institution:
Crawford Nursing Home 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2140 Mt. Holly St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARY TURNT LOWE

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Edwin Lowe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 4 | 2 | hr. min. |

9. Birthplace Aasning, N. Y. (Town, county, and state)
10. Usual Occupation retired attendance officer
11. Industry or business Balto. Public Schools

FATHER
12. Name Frederick Turnt
13. Birthplace Germany

MOTHER
14. Maiden Name Jennie Kaspar
15. Birthplace Germany

16 (a) Informant Mr. Edwin W. Lowe
(b) Address 2140 Mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/47 (month) (day) (year)
(c) Cemetery or crematory Olivet Cem.
Location St. Michaels, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by Local Reg.) (b) Registrar
FEB 7 - 1947 Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 1947 at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1 1944 to 2-5-1947 and that I last saw h[illegible] alive on 2-5 1947.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of Pancreas | 8 Mos. |
| Due to Fracture of left femur | 6 Mos. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 15/9
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Sept. 1946 (?) at ? M
(c) Where did injury occur? 2140 Mt. Holly St (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? no (Specify type of place)
(e) Means of injury got out of bed & fell to floor

23. Signature Howard J. Mellis M.D.
Address 2604 Garrison Blvd Date signed 2-6-47

Howard J. Mellis, M.D.

G48326

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 939

Registered No. G48326

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 822 N Carrollton Ave
(c) Hospital or institution: M. M. Carroll Aged Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 N. Carrollton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Frances Beverly

3 (b) If veteran, name war: I
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2 1867

8. AGE 79 Years | Months - | Days 3 | If less than one day: hr. min.

9. Birthplace North Carolina (City, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Heyson
13. Birthplace N. C.

MOTHER
14. Maiden Name Mary Heyson
15. Birthplace N. C.

16 (a) Informant Miss Asa Stewart
(b) Address 822 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-8-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md

18 (a) Funeral director Wm. Frazier A. Kennedy
(b) Address 578 W. Biddle St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 180 FEB 7 - 1947 Huntington Hillcrest, Md

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 5, 1947, at 9 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1946 to Feb 3 1947, and that I last saw her alive on Feb 3 1947

| Immediate cause of death | Duration |
|---|---|
| ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | 1½ yrs |
| Due to GENERALIZED ARTERIOSCLEROSIS | 2 yrs |
| Due to — | |
| Other Conditions — | |

(Include pregnancy within 3 months of death)

Date of operation NONE
Major findings of operation: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas W. Harris Jr. M. D.
Address 1824 N. Franklin St. Date signed 2-6-47

G18327

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

170c

G18327 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 S. Duncan Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles Benjerman Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | married |

6 (b) Name of husband or wife Florence Butler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 26, 1897

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 49 | 5 | 5 9 | hr. min. |

9. Birthplace St. Mary County, Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Florence Butler
(b) Address 108 S. Duncan St.

17 (a) Burial (b) Date thereof 2-8-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore - Md.

18 (a) Funeral director Mrs. Ida Bailey
(b) Address 1421 E. Jefferson St.

19 (a) (Date rec'd by registrar) (b) Kathryn Williams Registrar

VS 181 FEB 7 - 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 5, 1947, at 4 A.M. 30

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull, compound fracture of left leg bones,

Due to

Other Conditions Bronchopneumonia

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/1947 at 9:45 P. M. 2/2
(b) Where did injury occur? Pratt St. & South Broadway
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 2-5-47

X

G48328

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 D

Registered No. G48328

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert + 33rd Streets
(c) Hospital or institution: Union Memorial Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 87 days
(e) Length of stay in Baltimore (yrs., mos., or days) 41 years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County ——
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 W. 41st Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ——

3 (a) FULL NAME MARY EVELYN KARR

3 (b) If veteran, name war ——

3 (c) Social Security Account No. 215-01-3017

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife Richard Herman Karr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 15, 1906

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 40 | 10 | 21 | — hr. — min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation (Housewife) Clerk

11. Industry or business Gas & Electric Co.

MOTHER / FATHER

12. Name Louis Linselberger

13. Birthplace Baltimore, Maryland

14. Maiden Name Mary Richardson

15. Birthplace Baltimore, Maryland

16 (a) Informant Husband

(b) Address Same 1302 W. 41st St Balto-Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 8-1947 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road

19 (a) Entered by registrar (b) Williams, M.D. Registrar

FEB 7 - 1947 Huntington

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5 1947, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1947 to Feb 5 1947, and that I last saw her alive on Feb 4 1947

| Immediate cause of death | Duration |
|---|---|
| Cardio-respiratory failure | —— |
| Due to Carcinomatosis | 8 mos |
| Due to Carcinoma of rectum (recurrence) | 2 years |
| Other Conditions | —— |

(Include pregnancy within 3 months of death)

Date of operation March 1945

Major findings of operation: Carcinoma of rectum

of autopsy: ——

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ——
(b) Date of occurrence —— at —— M
(c) Where did injury occur? —— (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? —— While at work? —— (Specify type of place)
(e) Means of injury ——

23. Signature James McC. Fenner M. D.

Address Union Memorial Hospital Date signed Feb 5, 1947

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48329

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G48329

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2105 ORLEANS ST
(c) Hospital or institution: 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23 YRS

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2105 ORLEANS ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HANNAH LUSKIN

3 (b) If veteran, name war —
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | M. |

6 (b) Name of husband or wife AARON
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | | | hr. min. |

9. Birthplace LITH. (Town, county, and state)
10. Usual Occupation HOUSE WORK
11. Industry or business

FATHER
12. Name NOT KNOWN
13. Birthplace LITH

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace LITH

16 (a) Informant HUSBAND
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-9-47 (month) (day) (year)
(c) Cemetery or crematory MT CARMEL
Location OLD GERMAN HILL RD

18 (a) Funeral director Sark Lewis Inc.
(b) Address 1439 E. Balto St

19 (a) (Date received) (b) Registrar Huntington Williams, M.D.
FEB 7 - 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-7-47 19 , at VG M

21. I certify that death occurred on the date above stated; that I attended deceased from 1936 to Feb 6 1947, and that I last saw h[illegible] alive on Feb 6 1947

| Immediate cause of death | Duration |
|---|---|
| General arterio Sclerosis | 10 yrs |
| Chronic myocarditis | 10 yrs |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ruth or L. Solomon
Address 129 S Bway Date signed 2/7/47 M.D.

X

G48330 BC# BALTIMORE CITY HEALTH DEPARTMENT Registered No. G48330
FL - 107942 G69566 CERTIFICATE OF DEATH 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 9 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1632 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Gilliard - Mamie "B"

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1947

8. AGE: Years | Months | Days | If less than one day: 6 (or) hr. 18 min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Hugh Gilliard
13. Birthplace Ga.

MOTHER
14. Maiden Name Mamie LeeRembert
15. Birthplace S. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave

17 (a) Cremated (b) Date thereof 1-26-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Cemetery or crematory Baltimore City Crematory
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) FEB 7 - 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH Jan. 26 1947, at 1.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 26 1947, to Jan. 26 1947, and that I last saw h. alive on Jan. 26 1947.

| Immediate cause of death | Duration |
|---|---|
| Prematurity | Life |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes M. D.
Address Balto City Hosp Date signed 2-6-47

VS 150

G18331

AB-107654

BCH G68218

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

Registered No. G18331

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 123 N. Exter Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Girl Smith

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) January 16- 1947
8. AGE: Years | Months | Days: 15 | If less than one day: hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Smith
13. Birthplace Maryland

MOTHER
14. Maiden Name Daisy Lee
15. Birthplace North Carolina

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave. Balto Md
17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 2-6-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave.
18 (a) Funeral director
(b) Address
19 FEB 7 - 1947 (Date rec'd by Registrar) Huntington Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 31- 1947, at 12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-16- 1947 to 1-31- 1947, and that I last saw h. alive on 1-31- 1947.

Immediate cause of death: Prematurity — Duration: Life
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes M. D.
Address Balto City Hosp. Date signed Feb. 6 1947

VS 150

X

Birth Certificate

G48332 G-70188

AP-106142

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 159

Registered No. G48332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3402 Seneca St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Girl Neill

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F. | W | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3-1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 1 | hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Jesse Neill
13. Birthplace Md.

MOTHER
14. Maiden Name Etta Lee Vincent
15. Birthplace Va.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof 10 am 2.6.47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 FEB 7 - 1947 (c) Huntington Williams, M.D.
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4- 1947, at 6.46A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-3- 1947 to 2-4- 1947, and that I last saw her alive on 2-4- 1947.

| Immediate cause of death | Duration |
|---|---|
| Prematurity | Life |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes M.D.
Address Balto City Hosp Date signed Feb 6 '47

VS 150

X

G48333 BCH

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48333 Registered No.

AB-108015 669550 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 Oak Summit Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28-1947

8. AGE: Years | Months | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ralph Martin
13. Birthplace ?

MOTHER
14. Maiden Name Ethel Brewer
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof 2-6-47 10am
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern ave

18 (a) Funeral director
(b) Address

19 FEB 7 - 1947 Contington Williams M.D. Registrar
(Date Rec'd by Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1- 1947, at 8.20PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-28 1947, to 2-1- 1947, and that I last saw her alive on 2-1- 1947.

Immediate cause of death Prematurity — Duration Life

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nelson E. Hughes
Address Balto City Hosp Date signed Feb 2 '47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G48334 Dr. Brennan

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

✓ G48334 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3129 Chesley Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3129 Chesley Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Emil Goth

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-0101

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Josephine M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 11 | 25 | 24 hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Ent. Wire & Iron Co.
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Josephine M. Goth
(b) Address 3129 Chesley Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road 14

19 (a) FEB 7 - 1947 (Date rec'd by registrar) (b) Huntington Williamsville, Md.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5th, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1944 to Feb 5 1947.
and that I last saw h[illegible] alive on 19

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | |
| Due to Coronary Arteriosclerosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address 5217 Harford Rd Date signed 2-6-47

G48335
509270

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

157E

Registered No. G48335

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Pa. (b) County
(c) City or town Clarendon.
(If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D. 1.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Reid W Anderson Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-26-23

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 23 | 4 | 11/19 | hr. min. |

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Bookkeeper

11. Industry or business

FATHER
12. Name Reid W Anderson
13. Birthplace Pa.

MOTHER
14. Maiden Name Lillian Hayes
15. Birthplace Pa

16 (a) Informant Reeds.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 2/10/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Warren, Pa.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Stafford Rd.

19 (c) FEB 7 - 1947 Huntington Williams, M.D.
(Date rec'd by registrar) (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1947, at 7.26 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1947 to Feb 6 1947 and that I last saw him alive on Feb 6 1947.

| Immediate cause of death | Duration |
|---|---|
| Congenital heart disease Tetralogy of Fallot | Life |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation 2/5/47

Major findings of operation: Pulmonary stenosis

of autopsy: Same

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry L. Bahnson
Address Johns Hopkins Hosp. Date signed 2/7/47 M. D.

VS 150

G48336

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G48336

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1006 Granby Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 Granby Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** TOLBERT S. ROBOSSON

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary Hinchman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1864

8. AGE: Years 82 | Months 2 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Centerville, Penna.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name John Robosson
13. Birthplace Penna.

MOTHER 14. Maiden Name Caroline Deremer
15. Birthplace Penna.

16 (a) Informant Joseph D. Robosson
(b) Address 6212 Elliott Street

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb. 2, 1947 (month) (day) (year)
(c) Cemetery or crematory I.O.O.F.
Location Elmstone, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) FEB 7 - 1947 (Date rec'd by registrar) Huntington Williams, Md. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7 1947, at 12.14 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 to Feb 6 1947 and that I last saw alive on Feb 6 1947

Immediate cause of death: General Arterio Sclerosis / Chronic Myocarditis — Duration 5 yrs / 5 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. J. Solomon

Address 29 S. Broadway Date signed 2/3/47 M. D.

VS 150

G48337

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13B

Registered No. G48337

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 740 W Fayette St
(c) Hospital or institution: 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 740 W Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John H. Fellows

3 (b) If veteran, name war: W
3 (c) Social Security Account No. 241-05-4339

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Wht. | Marrid |

6 (b) Name of husband or wife: Viola
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21 1907

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 39 | 2 | 6 | hr. min. |

9. Birthplace Lancaster S C
(Town, county, and state)
10. Usual Occupation Painter Carpenter
11. Industry or business

FATHER
12. Name John H Fellows
13. Birthplace S C

MOTHER
14. Maiden Name Abbie Gardner
15. Birthplace S Carolina

16 (a) Informant Viola S Fellows
(b) Address 740 W Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/9/47 (month) (day) (year)
(c) Cemetery or crematory Suffolk Cemetery
Location Kirkham County S C

18 (a) Funeral director Fellows & Son
(b) Address 1219 E Coul St

19 FEB 7 - 1947 (Date rec'd by Registrar) (b) Huntington-Williams Mort

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 6 1947, at 4 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1947 to Feb 5 1947 and that I last saw h— alive on Feb 5 1947.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Tuberculosis | 2 |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harry Glassman M. D.
Address 753 W Fayette St Date signed Feb 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G48338

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

832

Registered No. G48338

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1709 Abbottston St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 Abbottston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Daniel Hardy.

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bessie C

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 24 1888

8. AGE: Years 58 | Months 3 | Days 12 | If less than one day: hr. min.

9. Birthplace Ga
(Town, county, and state)

10. Usual Occupation Roofer.

11. Industry or business

FATHER 12. Name Benjamin Hardy
13. Birthplace Ga

MOTHER 14. Maiden Name Ella Ewing
15. Birthplace Ga

16 (a) Informant Bessie Hardy
(b) Address 1709 Abbottston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/47 (month) (day) (year)
(c) Cemetery or crematory Lakewood
Location Baltimore Md

18 (a) Funeral director Fulton & O'Connor
(b) Address 1247 Edmondson Ave

19 (a) FEB 7 - 1947 (Date rec'd by Registrar) Huntington Williams (Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 6 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/4 1947 to 2/7 1947, and that I last saw him alive on 2/7 1947.

Immediate cause of death Cerebral hemorrhage — Duration 3 days.

Due to Arteris-sclerosis. — 7.

Due to

Other Conditions Arteritis de-formans. — 8-9 yrs.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. Willis Grayson M. D.
Address 3963 Greenmount Ave Date signed 2/7/47.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G18339

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

61

Registered No. G18339

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1630 E Fort Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1630 E Fort Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** George Edward Longo

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Fannie A
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17 1890

8. AGE: Years 56 | Months 6 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Clerk Baltimore

11. Industry or business

FATHER
12. Name Harry W Longo
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Coyne
15. Birthplace Ireland

16 (a) Informant Fannie A Longo
(b) Address 1630 E Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-8-47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Annex Catholic

18 (a) Funeral director Wathen & Doyle
(b) Address 1219 E Fort Ave

19 (a) Filed FEB 7 1947 (b) Registrar Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1947, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-2 1946 to 2-5 1947 and that I last saw h[illegible] alive on 2-5 1947

Immediate cause of death: Chronic Myocardial Degeneration — Duration 1 yr.

Due to: Diabetes Mellitus — Duration 10 yrs.

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. J. Ballod M. D.
Address 707 Fort Ave. Date signed 2-7-47

VS 150

X

G48340

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 134a

Registered No. G48340

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Howard + Madison Sts.
(c) Hospital or institution: Maryland General Hospital 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County —
(c) City or town Baltimore, 8
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 N. Hamilton
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs. Amy Marie Yewell

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emmert S. Yewell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 8 1892

8. AGE: Years 54 | Months 3 | Days 28 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, or state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown Colbert

13. Birthplace Md

MOTHER 14. Maiden Name Unknown Kirby

15. Birthplace Md

16 (a) Informant Emmert S. Yewell

(b) Address 1808 N. Durham St.

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 2/10/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md

18 (a) Funeral director Wilson & Son

(b) Address 1214 N. Eutaw St.

(a) Date rec'd by local registrar FEB 7 1947 (b) Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 2-6 1947, at 1:20 p M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 1-26 1947, to 2-6 1947, and that I last saw h alive on 2-6 1947.

| | Duration |
|---|---|
| Immediate cause of death Uremia | |
| Due to Bilateral Pyonephrosis and | |
| Due to Bilateral Multiple Calculi | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Same as above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carlton Brimfield M. D.

Address Maryland General Hosp. Date signed 2-6-47

G48341

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 120B

Registered No. G48341

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1539 E. North Ave.
(c) Hospital or institution: 8

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1539 E North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Sauerland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single~~, married, widowed, or ~~divorced~~: Widow

6 (b) Name of husband or wife: Julius
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10th 1877

8. AGE: Years 69 | Months 7 | Days 25 | If less than one day hr. min.

9. Birthplace Ireland (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Patrick Flemming
13. Birthplace Ireland

MOTHER
14. Maiden Name —
15. Birthplace Ireland

16 (a) Informant Mrs. Miller
(b) Address 2311 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 8th 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Fredrick Road

18 (a) Funeral director Leo S. Leo
(b) Address 1701-03 N. Patterson Park Ave

19 (a) Date received by registrar FEB 7 - 1947 Huntington Williams, M.D. Registrar

VS-150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5th 1947, at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1925 to Jan 5 1947 and that I last saw h.er alive on Jan 2 1947.

| Immediate cause of death | Duration |
|---|---|
| Ulceration Colitis | |
| Probably & pneum - Ad | 22yrs |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation Jan 14 25
Major findings of operation Ulceration Colitis
of autopsy: ✓

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ (Specify type of place) While at work? ✓
(e) Means of injury

23. Signature Chas F Bleke M. D.
Address 20 E Preston Date signed Feb 6-47

Howard J. Mercer, M.D. X

G48312 BCH G61779

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 119a

Registered No. G48312

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N. Carlin
(c) Hospital or institution: St. Josephs Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 3 MO.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2501 Christian St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Patricia a. Sullivan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/12/46

8. AGE: Years | Months 3 2 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER 12. Name Joseph Sullivan

13. Birthplace Md

MOTHER 14. Maiden Name ?

15. Birthplace

16 (a) Informant Mr. Sullivan

(b) Address 2501 Christian St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/47 (month) (day) (year)

(c) Cemetery or crematory New Leatherdale

Location Edmondson Ave.

18 (a) Funeral director Leo G. Leverte

(b) Address 1701-03 N. Patterson Park Ave

19 Filed FEB 7 - 1947 (Date rec'd by registrar) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/6/47 19 ; at 7:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1/1947 to 2/6 1947 and that I last saw h.e.r. alive on 2/5 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardiorespiratory failure | |
| Due to Diarrhea | |
| Due to | |
| Other Conditions Acidosis - & Dehydration (Include pregnancy within 3 months of death) | |

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard H. Young M. D.

Address St. Josephs Hosp. Date signed 2/6/47

VS 130

G48343

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 139a

Registered No. G48343

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun St.
(c) Hospital or institution Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town BALTIMORE City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** FLORENCE, CHASE (FLORENCE DORIS (FORSHEE PENNINGTON) CHASE

3 (b) If veteran, name war: No.

3 (c) Social Security Account No. 403-12-9725

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Joseph Chase
6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) APR 6, 1917

8. AGE: Years 29 | Months 10 | Days 0 | If less than one day ____ hr. ____ min.

9. Birthplace Kentucky (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name JOHN FORSHEE
13. Birthplace KENTUCKY

MOTHER — 14. Maiden Name [illegible]
15. Birthplace EVELINE MORTON KENTUCKY

16 (a) Informant Mr. Joseph Chase
(b) Address 1625 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 FEB 7 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 6 FEBRUARY 19 47 at 6 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-36 19 7, to 2-6 19 47 and that I last saw her alive on 2-6 19 47

Immediate cause of death: Acute PERITONITIS — Duration 5 da.
Due to:
Due to: TRANSECTION of Sigmoid at surgery
Other Conditions: CHRONIC PELVIC INFLAMMATORY DISEASE
Operation (within 3 months of death)
Date of operation 1-31-47
Major findings of operation: Extensive chronic pelvic inflammation; multiple adhesions
of autopsy: Not examined

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley B. Klyanowa, M.D.
Address Franklin Sq. Hosp. Date signed 2/8/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48314

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G48314

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2 N. Luzerne Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 N. Luzerne Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Henry Gross.

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-15-6638

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gertrude H. Gross

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) April 8-1899

8. AGE: Years 47 | Months 9 | Days 27 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Dockman

11. Industry or business Continental Oil Co.

FATHER
12. Name Fred Gross.
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Katie Fitz
15. Birthplace Md.

16 (a) Informant Gertrude H. Gross
(b) Address 2 N. Luzerne Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 8-47 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge Mem.
Location

18 (a) Funeral director John J. Miller
(b) Address 285 Jefferson St.

Date received FEB 7 1947 (Registrar) Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8th 1947, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14th 1946 to Jan 17th 1947. and that I last saw him alive on Jan 17th 1947

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | |
| Due to Myocardial Insufficiency | 2 |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Sumpter M. D.
Address 100 N Milton Ave Date signed 2/7/47

VS 150

G48315

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G48315

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1152 Cookside Dr
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) dea
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1152 Cookside Dr.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William A. Seibel

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-5395

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| male | White | Married |

6 (b) Name of husband or wife Mary A. Makovicz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 43 | | | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Truck driver

11. Industry or business Truck Driver

FATHER 12. Name Chas F. Seibel

FATHER 13. Birthplace Baltimore

MOTHER 14. Maiden Name Mary E. Thompson

MOTHER 15. Birthplace Baltimore

16 (a) Informant Mrs Wm A. Seibel

(b) Address 1152 Cookside Dr

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/47 (month) (day) (year)

(c) Cemetery or crematory Dolfield

Location Old Frederick Ave

18 (a) Funeral director Lahey & Sons

(b) Address 3 E Biddle St.

19 (a) (Date rec'd by local registrar) (b) Registrar

FEB 7 - 1947 Huntington Williams

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb. 7, 1947 at 3:55 P.M.

21. I certify that I took charge of the remains described above, held an Insp & Aug. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

**IMMEDIATE CAUSE OF DEATH** Arteriosclerotic Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D.
Medical Examiner.

Date signed 2/7/47

X

WERNSING

648340

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

Registered No. 648340

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1738 N Duncan St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1738 N Duncan St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Wernsing

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Christina Wernsing

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct - 13 - 1872

8. AGE: Years 74 | Months 3 | Days 24 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Wernsing
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Catherine Wrightsman
15. Birthplace Gettysburg Md

16 (a) Informant Mrs Bessie Bell
(b) Address 1516 N. Eutaw Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2 - 10 - 47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director John A Miller Jr
(b) Address 2425 E Oliver St

19 (a) Date received by Local Registrar FEB 7 1947 (b) Filing No. Huntington Williams Mort

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2 - 6 - 1947, at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6th 1946 to Feb. 6th 1947. and that I last saw h[illegible] alive on Feb. 1st 1947

Immediate cause of death: Coronary Thrombosis

Due to: Arteriosclerosis

Due to: Hypertension

Other Conditions: Surgery for myocardial infarct.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

| Duration |
|---|
| couple of months |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature K. Tramwell M. D.

Address 1623 E. Monument Date signed 2-7-47

V S 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48317

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 97

Registered No. G48347

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun St.
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 d
(e) Length of stay in Baltimore (yrs., mos., or days) ------

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County ----------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Charles & Centre Sts. St. James Apts.
(e) Citizen of foreign country? ---------- (Yes or No)
If yes, name country ----------

3 (a) **FULL NAME** May Weber

3 (b) If veteran, name war ----------

3 (c) Social Security Account No. ----------

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband ##### Frederick Weber

6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) ---------- 1897

8. AGE: Years 50 | Months ---- | Days ---- | If less than one day ---- hr. ---- min.

9. Birthplace Not obtainable
(Town, county, and state)

10. Usual Occupation ----------

11. Industry or business ----------

FATHER 12. Name John J. Howard
13. Birthplace Not obtainable

MOTHER 14. Maiden Name Mary Agnes
15. Birthplace ----------

16 (a) Informant Mrs. Mary McGann
(b) Address Rochambeau Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/47 (month) (day) (year)
(c) Cemetery ####### Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. K. Mears & Son
(b) Address 805 N. Calvert St.

19 (a) FEB 7 1947 (b) Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6 1947, at 8 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/24 1946 to 2/6 1947, and that I last saw her alive on 2/6 1947.

Immediate cause of death Cardiac Failure — Duration 7 days

Due to Self Inflicted Starvation — 30 days

Due to Cerebral Arteriosclerosis — 6 years

Other Conditions Arteriosclerotic Gangrene left foot
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward H. Southwick M.D.
Address Franklin Sq. Hosp Date signed 2/6/47

X

G48318

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 124B

Registered No. G18318

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 704 S. Rose St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 704 S. Rose St.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Germany

**3 (a) FULL NAME** Theresa Safar (Schaefer)

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife James Safar
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 11 — 1 — 1856

8. AGE: Years 80 | Months 3 | Days 5 | If less than one day — hr. — 18 min. 66

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER 12. Name Unknown
13. Birthplace Germany

MOTHER 14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant John Safar — Son
(b) Address 704 S. Rose St.

17 (a) Burial (b) Date thereof 2-10-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd., Balto

18 (a) Funeral director Tilly & Zeiler Inc
(b) Address 403 S. Wolfe St.

19 (a) FEB 7 - 1947 (b) Huntington Hill Registrar
(Date rec'd by registrar)

V S 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb. 6 — 1947, at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1947, to Feb. 6 1947, and that I last saw her alive on Feb. 5 1947

| Immediate cause of death | Duration |
|---|---|
| Contusion of Liver | 1-2-47 |
| Due to | |
| Due to | |
| Other Conditions None | |

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: —
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E A Hummack M. D.
Address 842 E 42nd Date signed 2-7-47

X

G18319

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 117a

G18319 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 640 S. Linwood
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Amelia Bankwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | S |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 Sept. 1910

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 36 | 4 | 27 | hr. min. |

9. Birthplace Baltimore Maryland
(Town, county, and State)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Louis D. Bankwell
13. Birthplace Italy

MOTHER
14. Maiden Name Laura McDonnell
15. Birthplace Balto

16 (a) Informant Louis D. Bankwell
(b) Address 640 S. Linwood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Selby & Beales Sr.
(b) Address 3 S. Eutaw St.

19 (a) FEB 7 1947 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH [redacted] 1947 at 3:15 A M

21. I certify that death occurred on the date above stated, that I attended deceased from [redacted] 1947, and that I last saw him alive [redacted] 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardio-resp. failure | |
| Due to Severe asthenia | |
| Due to perforated stomach ulcer | |
| Other Conditions Subtotal gastrectomy for Peptic Ulcer | |

(Influence pregnancy within 3 months of death)

Date of operation 1-22-47

Major findings of operation Perforated stomach ulcer

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roy B. Turner M. D.
Address West Balt. Gen. Date signed 2/3 1947

VS 150

G48350

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1710

Registered No. G48350

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hospital (Sp. Bon. City Hospital)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DEASEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 930 930 S. Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anna (Anna) Ritterbusch (Ritterbusch)

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14-1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | 1 | 23 | hr. min. |

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frank ?
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mortz Ritterbusch Son
(b) Address 2317 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/47 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn
Location Baston Ave

18 (a) Funeral director Selby & Jacobs
(b) Address 403 S. Wolfe St

19 FEB 7 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 2/6/47, 1947, at 12 20 M.

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull
Intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 2-5-46 at 1 P. M.
(b) Where did injury occur? Gilert & Potomac Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Passenger in auto struck by truck

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 2-6-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48351

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH √.61

Registered No. G48351

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1120 S. Bonsal St.
(c) Hospital or institution: V
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 S. Bonsal St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Arthur Jacob Hildebrand

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Nettie B. Phillips
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 1 | 8 | hr. min. |

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Garage Owner
11. Industry or business

FATHER
12. Name Samuel Hildebrand
13. Birthplace Virginia

MOTHER
14. Maiden Name Fannie Williams
15. Birthplace Virginia

16 (a) Informant Mr. Fay B. Hildebrand
(b) Address 96 Dundalk Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 10, 1947 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Eastern Ave.

18 (a) Funeral director Roland L. Fisher
(b) Address 2112 Dundalk Ave.

19 (a) FEB 7 - 1947 (Date rec'd by Registrar) (b) Huntington Mitchell

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/5 1947 at 1:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/9 1944 to 2/5 1947 and that I last saw h[illegible] alive on 11/7 1946

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | |
| Due to | |
| Due to | |
| Other Conditions H. B. V. D. + diabetes Mellitus (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operations
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Thos. Bergmeyer, M.D.
Address 463 Eastern Ave. Date signed 7/7/47

VS-150

942

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48352

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G48352

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2876 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Daniel A. Burk

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Amelia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/20/1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | - | 15 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Police Officer
11. Industry or business B. C. Police Dept.

FATHER
12. Name John A. Burk
13. Birthplace Delaware

MOTHER
14. Maiden Name Alverta Lippy
15. Birthplace Md.

16 (a) Informant Amelia M. Burk
(b) Address 2876 W. Balto. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director F. B. Herbert & Son
(b) Address 1300 Eutaw Place

FEB 7 1947 (Date rec'd by Registrar) (b) Registrar

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## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 4th 1947 at 8 P M

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: ~~natural causes~~ X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury.

23. Signature JOHN R. DAVIS, Investigator M.D.
Per: Howard J. Mullins, M. D.
Medical Examiner.
Date signed 2/7/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48353

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G48353

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 404 Washburn Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 5 11 9
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 404 Washburn Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Milton Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Jessie McCarty

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/31/1898

8. AGE: Years 48 | Months 10 | Days 34 | If less than one day hr. min.

9. Birthplace Baltimore (town, county, and state)

10. Usual Occupation Employee of

11. Industry or business B. T. C.

FATHER
12. Name Samuel
13. Birthplace Md.

MOTHER
14. Maiden Name Annie ?
15. Birthplace Md

16 (a) Informant Family
(b) Address 404 Washburn Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 2-8-47 (month) (day) (year)
(c) Cemetery or crematory Greenhill
Location Brooklyn

18 (a) Funeral director J. L. McCauley
(b) Address 120 E. Fort Ave.

19 (a) 2-7-1947 (b) Huntington Williams, M.D.
(Must be filed by registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7 1947, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to Feb 7 1947.
and that I last saw h[illegible] alive on Feb 2 1947.

| Immediate cause of death | Duration |
|---|---|
| coronary occlusion | |
| Due to hypertension | |
| chronic nephritis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Winston Williams M.D.
Address 302 Lafayette Ave Date signed 2/8/47

BCH D 69889

G48354 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G48354

## CERTIFICATE OF DEATH

1600a

1. PLACE OF DEATH — Registered No.

CITY OF BALTIMORE: (No. Volunteers of America Hosp. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. 3 mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Ellis Joseph Weighausman — If U. S. Veteran specify WAR

(a) Residence: No. 914 So. Ann St., Ward. (Usual place of abode) (If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. Color or Race | 5. Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| M | W | single |

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) Feb. 2 1947

| 7. AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| | | 3 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Infant

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto., Md.

FATHER

13. NAME Robert Rostein Weighausman

14. BIRTHPLACE (city or town) (State or country) Alsace, Europe

MOTHER

15. MAIDEN NAME Elizabeth Moffett

16. BIRTHPLACE (city or town) (State or country) Scotland

17. INFORMANT Mother

(Address) 814 St. Paul St.

18. BURIAL, CREMATION, OR REMOVAL

Place Date 19

19. UNDERTAKER University Medical School FEB 6 1947

(Address) Commissioner of Health

20. FEB 7 1947 19 Registrar

### MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Feb. 5, 1947

22. I HEREBY CERTIFY That I attended deceased from 2-4-46 to 2-5-47

I last saw him alive on 2-5-47 Death is said to have occurred on the date stated above, at 9:40 a.m.

The principal cause of death and related causes of importance were as follows:

| | Interval between onset and death |
|---|---|
| Cerebral Hemorrhage | 1 day |
| | |
| | |
| | |

Other contributory causes of importance:

Was an operation performed? No Date of

For what disease or injury?

Name of operation Clinical

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Julia Nitt M. D.

(Address) Vol. of America Hosp

VS 9

X

G48355

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 157E

Registered No. G48355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Harford
(c) City or town Havre de Grace (If outside city or town limits, write RURAL and give town)
(d) Street No. 202 Wilson St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

**3 (a) FULL NAME** Jean Boyd

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1-6-47

8. AGE: Years | Months | Days 3 wks | If less than one day ..... hr. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER — 12. Name Harold Boyd
13. Birthplace Md

MOTHER — 14. Maiden Name Freda Williams
15. Birthplace England

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a)..... (Burial, cremation, or removal) (b) Date thereof..... (month) (day) (year)

(c) Cemetery or crematory.....
Location Johns Hopkins Medical School FEB 7 1947

18 (a) Funeral director Commissioner of Health
(b) Address.....

FEB 7 1947 (Date rec'd by registrar) Herrington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb 5 1947 at 8:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30 1947 to Feb 5 1947 and that I last saw he alive on Feb 5 1947

| Immediate cause of death | Duration |
|---|---|
| (a) Congenital Heart | 18 hrs. |
| (b) Sinus Thrombosis | |
| Due to | |
| Due to | |
| Other Conditions Hypertrophic Fibrosis | |
| Sclerosis | |

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature [illegible]
Address Johns Hopkins Hospital (Date signed 2-9-47)

VS 150

Dr. George Lippy
452 S. Tall. Pk.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 477

Registered No. 648356

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2733 E. Monument St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2733 E. Monument St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John J. Kolbel

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-5943

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 8 | 19 | hr. min. |

9. Birthplace Germnay
(Town, county, and state)
10. Usual Occupation Steamfitter
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Margaret Kolbel
(b) Address 2733 E. Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5303 Harford Road

19 (a) (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

FEB 7 1947
VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 5, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1946, to Feb. 5 1947, and that I last saw h[illegible] alive on Feb. 5 1947.

Immediate cause of death: Carcinoma, left lung. — Duration: 1yr.+

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. J. Lippy M.D.
Address 452 S. Patterson Pk. Rd. Date signed 2/6/47

X

G18357

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G18357

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1827 Hilkelan St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1827 Hilkelan St.
(If no street, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles Prince

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Louise Prince
6 (c) If alive, give age —— years
7. Birth date of deceased (mo., day, yr.) July 16, 1867
8. AGE: Years 79 Months 6 Days 21 If less than one day hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Retired
FATHER 12. Name Unknown
13. Birthplace
MOTHER 14. Maiden Name Unknown
15. Birthplace
16 (a) Informant George Prince
(b) Address 1018 Ashton St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-8-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md
18 (a) Funeral director George L. Ephrat
(b) Address 2101 Frederick Ave.
19 (a) (b) Huntington Williams, Md
FEB. 8 - 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 6, 1947 at 7:50 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 20 June 1946 to Feb 6 1947 and that I last saw h.m alive on 15 Dec 1946
Immediate cause of death Acute Pulmonary Edema — Duration 12 Hrs.
Due to Chronic myocarditis — unknown
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Nathan Rosman
Address 296 S. Gilmor St. Date signed 2-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully studied. Write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write to

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

G48358

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G48358 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1324 W. Pratt St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1324 W. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Miller

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Amelia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1863

8. AGE: Years: 84 | Months | Days | If less than one day: hr. min.

9. Birthplace: Baltimore, Md
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business:

FATHER
12. Name: John Miller
13. Birthplace: Germany

MOTHER
14. Maiden Name: Mary Mueller
15. Birthplace: Germany

16 (a) Informant: Wm R. Miller (Son)
(b) Address: 946 Mc Elderry Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/37 (month) (day) (year)
(c) Cemetery: Woodlawn
Location: " Md

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

19 (a) FEB 8 1937 (Date rec'd by Registrar) (b) Huntington for Williams, M.D.

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 6 1937, at M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic cardiovascular disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Howard J. Walker M.D.
Medical Examiner.
Date signed 2-7-37.

C48359

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1170

Registered No. C48359

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address Caroline & Oliver Sts

(c) Hospital or institution St Joseph's Hospital

(d) Length of stay in hospital or inst. (~~years~~, ~~months~~, or days) 1

(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 219 E. Lafayette Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Mr. Edward Parrish

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name of ~~husband or~~ wife Achsah Parrish

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 28th 1890

8. AGE: Years 56 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Cashier

11. Industry or business Metro. Life Ins. Co.

FATHER

12. Name Edgar Lee Parrish

13. Birthplace Richmond Va.

MOTHER

14. Maiden Name Sophia D. Betts

15. Birthplace Balto. Md.

16 (a) Informant Mrs Achsah Parrish

(b) Address 219 E. Lafayette Ave.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/10/47 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Loudon Park

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St

19 (a) (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

FEB 8 1947

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb 7 1947 at 12 noon M

**21.** I certify that death occurred on the date above stated, that I attended deceased from Feb 6 1947 to Feb 7 1947 and that I last saw ~~him~~ her alive on Feb 7 1947

| Immediate cause of death | Duration |
|---|---|
| Peritonitis | |
| Due to Ruptured Duodenal ulcer | |
| Due to | |
| Other Conditions Pleural effusion, mechanical | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Ruptured ulcer

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Julius Lamonds M. D.

Address St Jos. Hosp. Date signed 2/7/47

G18360

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 97

Registered No. G18360

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3212 Evergreen Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3212 Evergreen Ave 14
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August Pauly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Emma E. Pauly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3, 1865

8. AGE: Years 81 | Months 5 | Days 23 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Cabinet Maker.

11. Industry or business Knabe Piano Co

FATHER
12. Name John Pauly
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant John Pauly
(b) Address 3212 Evergreen Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 10, 1947 (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Mr. & Mrs. John W. Teufel & Son

(b) Address 5311 Edmondson Ave.

19 FEB 8 - 1947 (Date rec'd by registrar) Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 6 1947, at 3.30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 17 1947 to Feb 4 1947 and that I last saw deceased alive on Feb 4 1947.

Immediate cause of death Hypostatic pneumonia

Due to Generalized arteriosclerosis & uremia.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

| Duration |
|---|
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. Brennan M. D.

Address 5217 Harford Rd Date signed 2-7-47

VS 150

X

G48361

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G48361 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 940 S. Conkling St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3503 Dillon St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Harry Henry Rau

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife Anna M. Sauter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 9 | 16 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Electrican
11. Industry or business

FATHER
12. Name John
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Baltimore

16 (a) Informant Mrs. Anna M. Rau
(b) Address 3503 Dillon St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) FEB 8 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 6, 1947, at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1946, to Feb 6 1947, and that I last saw h/m alive on Jan 15 1947

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | 7 |
| Due to Coronary Heart Disease | 7 |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Gaskel M. D.
Address 6th S. Conkling St. Date signed Feb 7, 1947

VS 150

G48362

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 477

Registered No. G48362

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1743 E.Federal St.
(c) Hospital or institution: 8 1/2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1743 E.Federal St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Charles A.Wenzel

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 47 | 0 | 0 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Printer
11. Industry or business U.S.Printing office Wash.D.C.

FATHER
12. Name John
13. Birthplace Baltimore

MOTHER
14. Maiden Name Emma Fulda
15. Birthplace Baltimore

16 (a) Informant Mrs. Howard L.Hanson
(b) Address 1743 E.Federal St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 Broadway.

FEB 8 - 1947 (Date rec'd by Registrar) (b) ~~Huntington Williams, M.D.~~ Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb-7- 1947; at 12.05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1- 1947, to Feb-7 1947, and that I last saw ~~him~~ alive on Feb-6- 1947

| Immediate cause of death | Duration |
|---|---|
| Edemia Lungs- | 1 Day |
| Due to Adeno-Carcinoma Lungs- | 3 months |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E. North Av Date signed 2/7/47

VS 150

G18363

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 B

Registered No. G18363

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 Forrest St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Russell N. Mayhew

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/19/07

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 39 | 7 | 16 | hr. min. |

9. Birthplace Westernport (Town, county, and state)
10. Usual Occupation Furniture Finischer
11. Industry or business

FATHER
12. Name William
13. Birthplace Franklin Md.

MOTHER
14. Maiden Name Viola Cummings
15. Birthplace Altamont Md.

16 (a) Informant Mrs. Grace Myers
(b) Address 1005 Forest St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Rd.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway, Huntingtown Williamsport, Md.

19 (Date received by registrar) FEB 8 - 1947 Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 5 Feb 1947, at 2-15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 24 1947, to 5 Feb 1947, and that I last saw h alive on 5 Feb 1947.

Immediate cause of death Carcinomatosis — Duration

Due to — over

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B Wells MD
Address Bay Jo Hosp Date signed 2-5-47

VS 150

X

G48364 WARREN

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93E

Registered No. G48364

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1104 N. Carrollton Ave
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 N. Carrollton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** John W. Warren

3 (b) If veteran, name war /

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | Married |

6 (b) Name of husband or wife Sallie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16-1862

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 84 | 11 | 20 19 | hr. min. |

9. Birthplace Bladensburg Md. (Town, county, and state)

10. Usual Occupation Retired Ministater

11. Industry or business

FATHER 12. Name Daniel Warren

13. Birthplace Md.

MOTHER 14. Maiden Name Jennetta Brown

15. Birthplace Md

16 (a) Informant Sallie Warren

(b) Address 1304 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-47 (month) (day) (year)

(c) Cemetery or crematory Arlington

Location Balto. Co.

18 (a) Funeral director Jesse W. Riddlemoser

(b) Address 436 W. Biddle St.

19 (a) FEB 8 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb. 5 1947, at 10 P. M

**21.** I certify that death occurred on the date above stated; that I attended deceased from July 19, 1946 to Feb 5, 1947 and that I last saw him alive on Feb 4, 1947

Immediate cause of death myocarditis — Duration 8 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

**PHYSICIAN** Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John E. L. Camper M. D.

Address 639 N. Carey St Date signed 2-6-47

VS 8

X

G18365

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G18365

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Maryland General Hosp. ?
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.A.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 Argyle Avenue
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

**3 (a) FULL NAME** Oliver J. Foreman

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | ? |

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) .....

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 ? | | | ..... hr. ..... min. |

9. Birthplace ? (Town, county, and state)
10. Usual Occupation ?
11. Industry or business .....

FATHER
12. Name ?
13. Birthplace .....

MOTHER
14. Maiden Name ?
15. Birthplace .....

16 (a) Informant Wm Clarke (Friend)
(b) Address 530 Sanford Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/37 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto Md

18 (a) Funeral director Chas Gorsuch
(b) Address 510-12 Cathedral Ave

19 (a) FEB 8 - 1937 (Date filed by registrar) Huntington Williams, Md. Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** January 24 19 37, at 2:30 P.M.

**21.** I certify that I took charge of the remains described above, held an Autopsy & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Leo death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH arteriosclerotic cardiovascular disease

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 1-25-37

VS 181

G48366

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G48366

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 W Cross Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Pickett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 2, 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 11 | 4 | hr. min. |

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Viola Lee
(b) Address 521 W Cross St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaac L. Brown's Son
(b) Address 108 W Montgomery St.

19 FEB 8 - 1947 (b) Huntington Williams, M.D.

VS 151

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 2/6/47 19..., at 1:12 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John Peters, M.D.
Medical Examiner.
Date signed 2/6/47

G18367 BC# 508185 G50674

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 32a

Registered No. G18367

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 418 Eisden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Calvin King

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4 - 1947

| 8. AGE: Years | Months | Days | If less than one day: hr. | min. |
|---|---|---|---|---|
| - | 7 | - | | |

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation -

11. Industry or business

FATHER 12. Name Ernest Lowere

13. Birthplace ?

MOTHER 14. Maiden Name Cecilia King

15. Birthplace Virginia

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-8-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem. Location Q. A. Co. Md.

18 (a) Funeral director Isaiah E. Brown & Son

(b) Address 108 W Montgomery St

19 (a) Filed by [illegible] (b) Registrar Huntington Wilson

FEB 8 1947

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb. 4 1947, at 10:20 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1947 to Feb 4 1947 and that I last saw him alive on Feb 3 1947.

| Immediate cause of death | Duration |
|---|---|
| Asthenia Acute | |
| Due to Diabetes Injection | 5 mos. |
| Due to | |
| Other Conditions Infectious Hepatitis | 2 weeks |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address Johns Hopkins Hospital Date signed 2-7-47

VS 150

G48368

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1790

Registered No. G48368

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 39 E. Wheeling St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** HARRISON SPOON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | D. |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 1892

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 | 11 | | hr. min. |

9. Birthplace VIRGINIA (Town, county, and state)

10. Usual Occupation IRON WORKER

11. Industry or business STRUCTURAL STEEL

FATHER
12. Name UNKNOWN
13. Birthplace VIRGINIA

MOTHER
14. Maiden Name — ORNDURFF
15. Birthplace VIRGINIA

16 (a) Informant CECIL SPOON
(b) Address 39 E. WHEELING ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2 10 47 (month) (day) (year)
(c) Cemetery or crematory MT OLIVET.
Location FREDERICK RD

18 (a) Funeral director JOHN F. DENNY, INC
(b) Address 715 LIGHT ST.

FEB 8 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 131

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 7, 1947, at 11.40 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Methyl Alcohol Poisoning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 4/2
(a) Date of injury 2/7/47 at M.
(b) Where did injury occur? 604 W. Redwood St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Drank Wood alcohol

23. Signature Howard J. MacLean M.D. Medical Examiner.
Date signed 2-8-47

X

G48369

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1463

Registered No. G48369

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Road.
(c) Hospital or institution: Ashburton Nursing Home. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Marlborough Apts.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** CELIA GOLDSMITH.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1871.

8. AGE: Years 75 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Herman Goldsmith,
13. Birthplace Germany.

MOTHER
14. Maiden Name Henrietta Moses,
15. Birthplace Germany.

16 (a) Informant Mr. Jack Mannes,
(b) Address 3509 Reisterstown Road.

17 (a) Burial (b) Date thereof 2.9.47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris Levinson & Son
(b) Address 1902 Eutaw Place.

19 (a) (b) Huntington Williams, M.D.
Registrar
Filed by registrar FEB 8 1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 7th. 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27 1946, to Feb. 7 1947, and that I last saw her alive on Feb. 7 1947

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of Stomach | 6 Months |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Manuel Levin M. D.
Address 4818 Reisterstown Rd. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REGULATIONS GOVERNING

X

G18370

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G18370

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd. & Guilford
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (years, months, or days) 21
(e) Length of stay in Baltimore (yrs., months, days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 35-14 Clifton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** LILLIE MAY OLIVER

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| FEMALE | WHITE | WIDOWED |

6 (b) Name of husband or wife Edwin de Cormis Oliver
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 1 | 2 | hr. min. |

9. Birthplace BALTIMORE, MD.
(Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name William P. Leese
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna E. Craig
15. Birthplace Baltimore, Md.

16 (a) Informant Hospital Records
(b) Address --

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (Date received by registrar) FEB 8 - 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 7, 1947, at 9:23 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 28, 1946 to Feb. 7, 1947, and that I last saw h[illegible] alive on Feb. 7, 1947.

Immediate cause of death CORONARY THROMBOSIS — Duration 2½ hrs.

Due to Arteriosclerosis

Due to

Other Conditions Bronchopneumonia & following ulcer.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Katherine Sprunt, M. D.
Address Union Memorial Hosp. Date signed 2-7-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48371

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G48371 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 37 years.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4121 Penhurst Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs. Concetta Serio

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. | 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|---|---|
| none | none | Female | White | Widowed |

6 (b) Name of husband or wife Joseph Serio
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 12, 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 3 | 24 | hr. min. |

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER: 12. Name Charles Voglia
13. Birthplace Italy

MOTHER: 14. Maiden Name Grace Glorisio
15. Birthplace Italy

16 (a) Informant Mr. John J. Serio
(b) Address 304 Preastman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 8 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 6 1947 at 9:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5 1947 to Feb. 6 1947 and that I last saw h alive on Feb. 6 1947

| Immediate cause of death | Duration |
|---|---|
| Cardio respiratory failure | |
| Due to Arteriosclerotic & V. Disease | |
| Cardiac Decompensation Stage IV | |
| Due to Bronchopneumonia | |
| Other Conditions Diabetes Mellitus | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Clarence E. McWilliams M.D.
Address Mercy Hospital Date signed 2-8-47

VS 150

93D

G18372

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G18372

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland ✓
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: The Seton Institute ✓3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35-4-7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 Hanover Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Italy

**3 (a) FULL NAME** Aristide Franzoni

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race white

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Ermentha Dell'Amico Franzoni

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 79 | Months unknown | Days | If less than one day hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation stone cutter

11. Industry or business

FATHER
12. Name Francesco Franzoni
13. Birthplace Italy

MOTHER
14. Maiden Name Rosa Bombarda
15. Birthplace Italy

16 (a) Informant The Seton Institute
(b) Address 6420 Reisterstown Rd., Balto. 15, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd

19 (c) FEB 8 1947 (Date received by Registrar) Huntington Williams, M. D.

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 2/7 1947, at 4:20 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from April 1946 to 2/7 1947.
and that I last saw he alive on 2/7 1947.

Immediate cause of death Cardio Vascular Collapse — Duration 3 days
Due to Arteriosclerosis
Due to
Other Conditions Hypertension Paranoid State — 25 yrs
(Including pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. D'Alagna M. D.
Address 2316 Madison Ave Date signed

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Fill correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~48373~~

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 181

Registered No. G48373

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5122 Frankstown Rd.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 D.
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yr.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5122 Frankstown Rd. (If rural give location)
(e) Citizen of foreign country? Md. (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Bessie C. Zimmerman.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | S |

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6 - 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 0 | 1 | hr. min. |

9. Birthplace Balto Co. (Town, county, and state)

10. Usual Occupation Home Mother

11. Industry or business

FATHER
12. Name F. M. Zimmerman
13. Birthplace Md

MOTHER
14. Maiden Name Cordelia William
15. Birthplace Balto Md.

16 (a) Informant F M Zimmerman
(b) Address 5122 Frankstown Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-10-1947 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave.

19 FEB 8 - 1947 (Date rec'd by registrar) Huntingtown Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/7 1947 at 2.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/3 1947 to 2/7 1947, and that I last saw her alive on 2/7 1947

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure due to burns | |
| due to explosion 1st 2° | |
| Due to Burns covering 3/4 of Body | |
| Due to | |
| Other Conditions — | |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident 24 3
(b) Date of occurrence 2/3/47 at 1 A.M.
(c) Where did injury occur? 5122 Frankstown Rd Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? —
(e) Means of injury Burns Caught on fire Oil stove explosion
23. Signature H. Mitchell M.D.
Address Md. Gen. Hosp Date signed 2/7/47 M. D.

VS 150

For Surg. Hafferk, by Howard J. Andersen, M.D. X

G18374 BCH G69442 History No. 179741 G18374

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 157E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town Sparks (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Black | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 1, 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 6 days | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Raymond Johnson
13. Birthplace Sparks, Md

MOTHER 14. Maiden Name Helen Johnson
15. Birthplace Sparks Maryland

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 8 47 (month) (day) (year)
(c) Cemetery or crematory Stephenson MF
Location Sparks, Md

18 (a) Funeral director G. Wm. Brooks
(b) Address Sparks, Md.

19 (a) FEB 8 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 7 19 47, at 7:10AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 19 47 to Feb. 7 19 47 and that I last saw her alive on Feb. 7 19 47

| Immediate cause of death | Duration |
|---|---|
| Pulmonary edema due to cardiac failure | |
| Due to congenital heart disease | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Russell Jordan M. D.
Address Johns Hopkins Hospital Date signed 2-7-47

VS 150

X

G18375

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G18375

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Mercy Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Born Here
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 4221 Eastview Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country No

**3 (a) FULL NAME** Joseph Roger Ozmon (OZMON)

3 (b) If veteran, name war: WORLD WAR #1
3 (c) Social Security Account No. 213-03-3979

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife: Frances Martin Ozmon
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) May 31, 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 8 | 6 | hr. min. |

9. Birthplace Centreville, Md. (Town, county, and state)
10. Usual Occupation Credit Manager
11. Industry or business Candy Business

FATHER: 12. Name Joseph W. Ozmon
13. Birthplace Maryland

MOTHER: 14. Maiden Name Minnie Satterfield
15. Birthplace Maryland

16 (a) Informant Mrs. Frances Martin Ozmon
(b) Address 4221 Eastview road, Northwood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Grannis Sons Inc
(b) Address 1647 N. Mt. Royal Ave
Interring for Williams, Md.

FEB 8 - 1947
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH July 7 1947 at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1946 to July 7 1947 and that I last saw h[illegible] alive on July 7 1947

Immediate cause of death

| | Duration |
|---|---|
| Cerebral Thrombosis | July 7 1947 |
| Due to Coronary | |
| Due to Thrombosis | 1946 |
| Other Conditions Hypertension (Include pregnancy within 3 months of death) | 1946 |
| Date of operation None | |
| Major findings of operation: None | |
| of autopsy None | |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. P. Clautice M. D.
Address 3013 St Paul St Date signed July 7/47

VS 150

G48376 BALTIMORE CITY HEALTH DEPARTMENT G48376
# CERTIFICATE OF DEATH 1312

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2338 Reisterstown Rd
(c) Hospital or institution:
15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2338 Reisterstown Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Max Smulovitz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Widowed |

6 (b) Name of husband or wife Hannah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 6 0 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant: Irvin Smulovitz
(b) Address 5716 Narcissus Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-9-47 (month) (day) (year)
(c) Cemetery or crematory Wash Blvd
Location Wash Blvd

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St

19 (a) (b)
(Date paid by registrar) Registrar

F 9 1947
VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1947; at 10 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1946 to Feb. 8, 1947. and that I last saw h alive on Feb. 8, 1947.

Immediate cause of death Chronic Nephritis — Duration 7

Due to

Due to

Other Conditions Uremic Coma — 3 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature M. D.
Address 1109 N. Calvert St Date signed 2/8/47

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48377

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

44B

G48377 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Fla. (b) County
(c) City or town Miami Springs (If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Elm Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Erna Anna Carney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jack

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-7-14

8. AGE: Years 33 | Months 1 | Days 1 | If less than one day hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Fred Englehardt
13. Birthplace Germany

MOTHER 14. Maiden Name Minnie Knaus
15. Birthplace Germany

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof Feb 11 1947 (month) (day) (year)
(c) Cemetery or crematory Memorial Park
Location Dayton Ohio

18 (a) Funeral director John O Mitchell & Sons.
(b) Address 1900 Eaton Place

19 (a) Filed FEB 9 1947 (b) Registrar's signature Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 1947 at 10 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 31 1947 to Feb 8 1947 and that I last saw her alive on Feb 8 1947

| Immediate cause of death | Duration |
|---|---|
| Undetermined | |
| Due to | |
| Due to | |
| Other Conditions Mediastanal tumor (Include pregnancy within 3 months of death) | |

Date of operation 2/7/47

Major findings of operation: Mediastinal tumor

of autopsy: Not completed

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry K. Bahman

Address Johns Hopkins Hospital Date signed 2/8/47 M D

G48378

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

G48378 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1211 Light St.
(c) Hospital or institution: So. Balto Gen'l Hosp. 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town 1420 Light St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto - Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Zella. S. Watts.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W. | M |

6 (b) Name of husband or wife Chas. Watts.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1907

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 39 | 7 | | hr. min. |

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Letherbud
13. Birthplace W. Va.

MOTHER
14. Maiden Name Mary Deane
15. Birthplace W. Va.

16 (a) Informant Charles J. Watts
(b) Address 1420 Light St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/8/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Parkersburg, W. Va.

18 (a) Funeral director Geo. O. Krause & Son
(b) Address 1216 E. Charles St

19 (a) (Date received by registrar) (Registration No.)

FEB 9 1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 7, 1947 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29 1947 to 2-7 1947 and that I last saw h[illegible] alive on 2-7 1947.

Immediate cause of death: Generalized carcinomatosis. — Duration

Due to — over

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: above - 2-7-47

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 1211 Light St Date signed 2-7-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 117a

G48379 ✓ Registered No. G48379

G48379

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2345 Harford rd.
(c) Hospital or institution: 8

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County City
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2345 Harford rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Joseph Kelly Sr.

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 214-01-9294

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Laura K. Knighton
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 3 | 22 | ###### hr. ..... min. |

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Bottler
11. Industry or business Brewery (Globe)

FATHER
12. Name Jeremiah Kelly
13. Birthplace Ireland

MOTHER
14. Maiden Name Jane Barragery
15. Birthplace Ireland

16 (a) Informant John J. Kelly Jr.
(b) Address 206 Courtland Ave. Towson

17 (a) Burial (b) Date thereof 2/12/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue, Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

FEB 9 1947

19 (a) ..... (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

V S 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 8th 19 47, at ..... M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-6-46 19..., to ..... 19..., and that I last saw h/m alive on 2-7- 1947

| Immediate cause of death | Duration |
|---|---|
| Hemorrhage Intest. - Ulcer Duodenum | 2 days |
| Due to Septic Ulcer | 6 mos. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 5214 York Rd. Date signed 2/8/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48380 ✓ G48380

G48380

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 117a

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1106 E. North Avenue
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 E. North Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Harmar C. Kenney

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 577-16-2141

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Josephine Lee Merson
6 (c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.): Dec. ? 1878

8. AGE: Years: 68 | Months: 2 | Days: ? | If less than one day: ##### hr. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Clerk
11. Industry or business: Unemployed

FATHER
12. Name: Patrick H. Kenney
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Mary E. Woods
15. Birthplace: Baltimore, Md.

16 (a) Informant: Helen L. Kenney
(b) Address: 1106 E. North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2/11/47 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Edmondson Avenue Balto. Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

FEB 9 1947

19 (a) (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: February 8 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6 1947, to 2/8 1947 and that I last saw h[illegible] alive on 2/7 1947.

| Immediate cause of death | Duration |
|---|---|
| | |
| Due to: Gastric Hemorrhage | |
| Due to: from chronic ulcer | |
| Other Conditions: stomach | |

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Frances J. Kirby M. D.
Address 110 E. North Ave Date signed 2/8/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CWK-107397 G48381

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

95B ✓ G48381 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 1-
(e) Length of stay in Baltimore (yrs., mos., or days) 55- 2- 20-

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1859 N. Durham Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Sophie Cecelia Stockman

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| None | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife George T. Stockman
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) November 18-1893

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | 2 | 20 | ..... hr. ..... min. |

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Nicholas Schonberger
13. Birthplace Virginia

MOTHER
14. Maiden Name Margaret Selman
15. Birthplace Germany

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 2/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1755 Harford Avenue

(a) (b)
(Date received by registrar) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 8 1947, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 7 1947 to Feb. 8 1947, and that I last saw h.. alive on Feb. 8 1947.

| Immediate cause of death | Duration |
|---|---|
| Rheumatic Pneumonia | 10 yrs |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy No

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Rowell Huffington M. D.
Address 6 Feb 47 Baltimore City Date signed

Huntington Williams, M.D.

X

G48382 ✓ G48382

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 883 W. LOMBARD ST
(c) Hospital or institution: HOME 18

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 883 W. LOMBARD ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES A. JUSKEVICH

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| MALE | WHITE | MARRIED |

6 (b) Name of husband or wife SALLY RUDANSKAS
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) AUG. 15-1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 5 8 | 15 22 | hr. min. |

9. Birthplace LITHUANIA (Town, county, and state)
10. Usual Occupation PAPER HANGER
11. Industry or business

FATHER
12. Name ANTHONY JUSKEVICH
13. Birthplace LITHUANIA

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace

16 (a) Informant MRS. HELEN NIEWERTH
(b) Address 3428 MAYFIELD AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 10. 47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location BALTIMORE. MD

18 (a) Funeral director THOS. J. KENNY. INC
(b) Address HOLLINS and GILMOR STS

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 9 - 1947
VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1947 at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1946 to Feb 6 1947 and that I last saw [illegible] alive on Feb 2 1947.

Immediate cause of death: Carcinoma Stomach — Duration: 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

### PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John P. Ulrich, Jr.
Address 1227 Wash. Blvd Date signed 2/5/47 M D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The Physicians' part is especially important. Be sure to write the causes of death clearly and legibly.

G48383 BG# G52327 ✓ G48383

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 119a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The space for "Usual Occupation" is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address W. FAYETTE ST
(c) Hospital or institution: BON SECOURS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2432 CALVERTON Hgts Av.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Degen

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | S |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 28-46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 6 | 11 | hr. min. |

9. Birthplace BALTO, MD
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name JOSEPH L. DEGEN
13. Birthplace BALTO. MD

MOTHER
14. Maiden Name DORIS PRICE
15. Birthplace BALTO, MD

16 (a) Informant JOSEPH L DEGEN
(b) Address 2432 CALVERTON HGTS. AV.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/10/47 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER.
Location 4430 BELAIR RD CITY

18 (a) Funeral director A. ROHDE & SON.
(b) Address 3927 EDMONDSON AV.

19 1947 (Date rec'd by registrar) Burton Williams, M.D. (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1947, at 1 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 28 1947 to Feb 8 1947 and that I last saw him alive on Feb 7 1947

| | Duration |
|---|---|
| Immediate cause of death: Cardiac failure | Sudden |
| Due to: Gastro-enteritis | 12 days |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Farber M.D.
Address Bon Secours Hosp, Balto Date signed 2-8-47

VS 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D 48384- Revity

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. D 48384

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address ..... 22 1/2
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1122 Hanover Street (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

**3 (a) FULL NAME** Michael Wm Revity

3 (b) If veteran, name war: W. W. #2

3 (c) Social Security Account No. 217-01-0799

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of ~~husband~~ or wife Irene Revity

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 15th 1916

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 30 | 3 | 22 24 | ..... hr. ..... min. |

9. Birthplace Boughtkill Pa. (Town, county, and state)

10. Usual Occupation Burner

11. Industry or business Bethlehem Steel Co.

FATHER
12. Name John Revity
13. Birthplace Russia

MOTHER
14. Maiden Name Anna Kennedy
15. Birthplace Russia

16 (a) Informant Irene Revity
(b) Address 1122 Hanover St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/11/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ U. S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1207 St. Paul St

19 (a) Registered FEB 10 1947 Huntington Williams, M.D.

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 8, 1947 at 9 50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to .....

Other Conditions Hypertrophy, dilatation & Chronic Myocardial Degeneration
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Howard J. Mullis M.D.
Medical Examiner.
Date signed 2-8-47

G48385

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1176

G48385 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 112 E. Pennsylvania Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ora McCowan

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widowed |

6 (b) Name of husband or wife Everett McCowan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/15/1905

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 41 | 4 | 23 | hr. min. |

9. Birthplace Kentucky (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Caleb Smallwood
13. Birthplace Kentucky

MOTHER
14. Maiden Name Louisa Stone
15. Birthplace Kentucky

16 (a) Informant Gladys Gaston
(b) Address 112 E. Penna Ave

17 (a) Removal (b) Date thereof 2/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory McCowan Private
Location Jenkins, Kentucky

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) (b)
(Death rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb 8 19 47, at 4½ A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 24 19 47 to Feb 8 19 47.
and that I last saw h alive on 19
Immediate cause of death Acute Pulmonary Edema — Duration
Due to Cardiac disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Feb 5, 1947
Major findings of operation: Bicornual uterus
of autopsy: Acute pulmonary edema

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward P. Smith Jr. M.D.
M. D.
Address Mercy Hospital Date signed 2-8-47

VS 150

G48386 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G48386

# CERTIFICATE OF DEATH

81a

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 13 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County St Mary's
(c) City or town Leonard Town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Joseph Redmond Redman Sr.
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Mrs Catherine Redman
6 (c) If alive, give age 26? years

7. Birth date of deceased (mo., day, yr.) Jan 25, 1916

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 31. | 0 | 13 | ____ hr. ____ min. |

9. Birthplace Maryland. (town, county, and state)
10. Usual Occupation Asst Mechanic
11. Industry or business Garage

FATHER
12. Name Joseph Redmond Redman
13. Birthplace Maryland.

MOTHER
14. Maiden Name Anna Beam
15. Birthplace Maryland. Redman

16 (a) Informant Mrs Catherine Redman
(b) Address 2208 Aisquith Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 10 '47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3001 Frederick Rd
18 (a) Funeral director Harry W Seitz
(b) Address 4101 Edmondson Ave

FEB 9 - 1947 (a) (Date rec'd by registrar) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7, 1 1947 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1947 to Feb 7 1947, and that I last saw him alive on Jan 7 1947.

| Immediate cause of death | Duration |
|---|---|
| Meningitis, acute organism unknown. | 4 wks. |
| Encephalitis, acute, organism unknown. | 2 wks. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Bachrach M. D.
Address Church Home & Hosp Date signed Feb 7, 47.

VS 130

G48387 ✓ G48387

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 927

Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Hayward Ave
(c) Hospital or institution Pine Crest Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mo.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Del (b) County
(c) City or town Wilmington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 N. Rodney St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Clara A Ball

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widow |

6 (b) Name of husband or wife Wm. A. Ball
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14 - 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | 0 | 14 | hr. min. |

9. Birthplace Delaware Ohio
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

**FATHER**
12. Name John W. McDaniell
13. Birthplace Wilmington - Del

**MOTHER**
14. Maiden Name Ella Mendinhall
15. Birthplace Delaware

16 (a) Informant John Horace Ball
(b) Address 900

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 11-47 (month) (day) (year)
(c) Cemetery or crematory Wilmington & Brandywine
Location Wilmington Del.

18 (a) Funeral director Ellsworth Funeral Home
(b) Address 3911 Liberty Heights Ave

19 (a) (Date received by registrar) (b) Hunting Park Ave

FEB 9 1947

Vs-750

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1947, at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1946 to Feb 7 1947 and that I last saw h[illegible] alive on Feb 7 1947

| | Duration |
|---|---|
| Immediate cause of death: Pneumonia | 6 wks |
| Due to: My resultes Chronic valvular | 10 yrs. |
| Due to: | |
| Other Conditions: — | |

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation —
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide? None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature [signature] M. D.
Address 3534 Ellerslie Date signed 9/2/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct ... is especially important. Physicians: please write the causes of death clearly and legibly.

G41838

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 121

✓ G43383

Registered No. .....

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4½ yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country .....

**3 (a) FULL NAME** Lacy, Medford Wray

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| WW I | ? |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Mattie Brelser Lacy
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1899

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 48 | 0 | 19 | ..... hr. ..... min. |

9. Birthplace Charlottesville, Va.
(Town, county, and state)
10. Usual Occupation Inspector
11. Industry or business Aircraft industry

FATHER
12. Name Wray B. Lacy
13. Birthplace Goochland, Va.

MOTHER
14. Maiden Name Maggie C. Bolser
15. Birthplace Rochbridge, Va.

16 (a) Informant Records
(b) Address U. S. Marine Hsopital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb-11-1947 (month) (day) (year)
(c) Cemetery or crematory Riverview Cemetary
Location Charolottesville, Va
(a) Funeral director Williams Coote Inc
(b) Address 217 E. Payne st.

19 (a) ..... (b) ..... Registrar
(Date rec'd by registrar)

FEB 12 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 9, 1947, at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1, 1947, to Feb. 9, 1947, and that I last saw him alive on Feb. 8, 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary artery sclerosis with occlusion and myocardial infarction | unknown |
| Due to abscess periappendiceal | 1 wk. |
| Due to ..... | ..... |
| Other Conditions ..... | ..... |

(Include pregnancy within 3 months of death)
Date of operation Jan. 31, 1947
Major findings of operation: 500cc thick pus.
of autopsy as above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Joe M. Chisolm
Address Marine Hospital Date signed 2/9/47

FEB 12 1947

X

G48389

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

Registered No. G48389

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3634 E. Roberts Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimcre
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3634 E. Roberts Place
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARY (MAMIE) DRESCHER

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | married |

6 (b) Name of husband or ~~wife~~ John C. Drescher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | 5 | 17 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Geary
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant John C. Drescher - husband
(b) Address 3634 E. Roberts Place

17 (a) Burial (b) Date thereof 2/10/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~c[illegible]~~ Holy Redeemer
Location Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) (Date rec'd by registrar) FEB 10 1947 (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 6 1947 at 2 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 6 1947, to Feb. 6 1947, and that I last saw her alive on Feb. 6 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Embolus | 5 hrs. |
| Due to Metastatic Carcinoma of R+ Breast | 1 yr. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ernest Lewis, M.D.
Address 1601 N. Broadway Date signed 2/7/47

G48390

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G48390 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address ..... 11
(c) Hospital or institution Maryland Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) .....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County .....
(c) City or town Balto (If outside city or town limits write RURAL and give town)
(d) Street No. 701 N. Calvert St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

**3 (a) FULL NAME** Isabella Rowland

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Frank Rowland
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Apr 29th 1878

8. AGE: Years 68 | Months 9 | Days 9 | If less than one day ..... hr. ..... min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business .....

FATHER
12. Name James Barclay
13. Birthplace England

MOTHER
14. Maiden Name Martha Unknown
15. Birthplace England

16 (a) Informant Mrs. R. G. Richards
(b) Address 701 N. Calvert St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/10/47 (month) (day) (year)
(c) Cemetery or crematory Oakridge
Location Altoona Pa

18 (a) Funeral director Wilson & Son
(b) Address 1214 Eutaw St

FEB 10 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 191

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb 8th 1947, 12:20 P.M.

21. I certify that I took charge of the remains described above, held an Aug & Insp Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Natl death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work?
(d) Means of injury .....

23. Signature William G Kerfoot M.D.
Medical Examiner.
Date signed Feb 8th 47

G48391

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. G48391

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5607 Birchwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5607 Birchwood ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** James F Scroggins

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Fannie A. Scroggins
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 3- 1868
8. AGE: Years 78 | Months 9 | Days 6 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Wholesale Fish Dealer
11. Industry or business Self

FATHER
12. Name Samuel Scroggins
13. Birthplace Scotland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Unknown

16 (a) Informant Fannie A Scroggins (Wife)
(b) Address 5607 Birchwood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Baltimore
18 (a) Funeral director Wm Cook, Inc.
(b) Address 1217 St Paul St
19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 1947 at 3 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9 1946 to Feb 9 1947, and that I last saw alive on Feb 8 1947

| Immediate cause of death | Duration. |
|---|---|
| Coronary Embolism | 30 min |
| Due to Coronary Infarction | 5 mo |
| Mitral Regurgitation | 1 yr |
| Due to Arterio Sclerosis | 1 yr |
| Hypertension | 1 yr |
| Other Conditions. Chr. Interstitial Nephritis | 1 yr |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. F. A. Stevens M.D.
M. D.
Address 2818 Harford Rd Date signed 2-9-47

VS FEB 10 1947

92B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18392

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 55E

Registered No. G18392

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 214 Cliftwood
(c) Hospital or institution: 8

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 214 Cliftwood (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARGARET BAUER

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Frederick C
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov 24. 1892

8. AGE: Years 54 | Months 2 | Days 14 15 | If less than one day hr. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Alonzo Pratt
13. Birthplace: Md.

MOTHER
14. Maiden Name: Ella Ryan
15. Birthplace: Md

16 (a) Informant: Frederick C Bauer
(b) Address: 214 Cliftwood Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/47 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Fairvale Md

18 (a) Funeral director: Wilson Cook Inc
(b) Address: 214 Cliftwood Ave

19 (a) (Date rec'd by registrar) (b) 0 Registrar

FEB 10 1947

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9/47 19 , at 1:35 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Generalized Carcinomatosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury (b) M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 2/9/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48393

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 47D

G28393

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3308 Walbrook Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Herbert M. Mitchell

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Edna
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Apr 21 1883
8. AGE: Years 63 | Months 2 | Days 7 | If less than one day: hr. min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Salesman
11. Industry or business: Carroll Ind Finish Co
FATHER 12. Name: Monroe Mitchell
13. Birthplace: Md
MOTHER 14. Maiden Name: Susie (Wakeman)
15. Birthplace: Md
16 (a) Informant: Robert E. Mitchell
(b) Address: 2821 Glendale Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2/10/47 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Hollywood Md
18 (a) Funeral director: Gilpin Johnson
(b) Address: 1214 Park Ave
19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/7 1947, at 4 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 12/17 1947 to 2/7 1947 and that I last saw him alive on 2/7 1947

Immediate cause of death: Cardiac failure — Duration: 3 days
Due to: Mitral stenosis and coronary sclerosis — 20 years
Due to:
Other Conditions: Pneumonectomy for carcinoma, lung
(Include pregnancy within 3 months of death)
Date of operation Jan 21 1947
Major findings of operation: Carcinoma, L. lung.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature: Lawrence S. Cannon, M.D.
Address: St Agnes Hosp Date signed 2/7/47

FEB 10 1947

VS 150

G48394

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G48394 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 412 N. Colvin Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5'
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 412 N. Colvin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anthony Genovese
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex m.
5. Color or race w.
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 5-1881
8. AGE: Years 65 Months 10 Days 2 If less than one day hr. min.
9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Fruit Dealer
11. Industry or business
FATHER 12. Name James Genovese
13. Birthplace Italy
MOTHER 14. Maiden Name Ursula Curreri
15. Birthplace Italy
16 (a) Informant Sadie Genovese
(b) Address 412 N. Colvin Street
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 11-1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location 4430 Belair Road
18 (a) Funeral director Joseph Fasace Inc.
(b) Address 2018 Greenmount Ave
19 (a) (Date rec'd by registrar) FEB 10 1947 Registrar
Verified Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 7 1947, at 2.30 P. M.
21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to 7 Feb 1947, and that I last saw h[im] alive on 7 Feb 1947.

| | Duration |
|---|---|
| Immediate cause of death: Uremia | 1 week |
| Due to: cardio-vascular-renal disease | |
| Due to: arteriosclerosis | |
| Other Conditions: diabetes | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Samuel Silverfield M.D.
Address 714 E. Preston St. Date signed 8 Feb 1947

131a

G48395

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 43a

Registered No. G48395

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 727 S. Ellwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 727 S. Ellwood Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Thomas Henry Myrick

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Mary Myrick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26. 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 5 | 13 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation House Painter
11. Industry or business

FATHER
12. Name Thomas Myrick
13. Birthplace Virginia

MOTHER
14. Maiden Name Anna Mary Fryers
15. Birthplace Bayl. Md.

16 (a) Informant George D. Myrick
(b) Address 1718 Bayard Ave. Dundalk Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 11. 47 (month) (day) (year)
(c) Cemetery or crematory Mount Carmel
Location

18 (a) Funeral director Frank V. Pipitone
(b) Address 2918 E. Baltimore St.

19 (a) (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar) FEB 10 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/8 1947, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/4 1947 to 2/8 1947.
and that I last saw h[illegible] alive on 2/7 1947.

| Immediate cause of death | Duration |
|---|---|
| Hemiplegia Apoplectic | 4 days |
| Due to Hypostasis | |
| Due to Arteriosclerosis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wright S. Sadler
Address 3323 E. Baltimore St. Date signed 2/9/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G48396 BH# 68487

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

107

G48396 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4331 Washington Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** James Parker

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | W | S. |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 23, 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 15 14 | hr. min. |

9. Birthplace MD
(Town, county, and state)

10. Usual Occupation

11. Industry or business

**FATHER**
12. Name LLOYD PARKER
13. Birthplace MD.

**MOTHER**
14. Maiden Name MARION
15. Birthplace MD.

16 (a) Informant Lloyd Parker
(b) Address 433 Washington Blvd.

17 (a) Burial (b) Date thereof 2/10/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore

18 (a) Funeral director MARTIN FAHEY & SONS
(b) Address 1827 W. NORTH AVE.

19 (a) (b)
(Date rec'd by registrar) Registrar

VS Form FEB 10 1947 Washington Blvd

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 2/6 1947, at 3 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2/5 1947 to 2/6 1947, and that I last saw h[illegible] alive on 2/4 1947.

Immediate cause of death Respiratory Failure — Duration

Due to Bronchopneumonia

Due to Monilia infection of mouth

Other Conditions Marasmus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature Henry W. Hollis M.D.
Address St. Agnes Hosp. Date signed 2-8-47

G18397
CHK-108275

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 157E

✓ G18397 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Hr. 5 Min.
(e) Length of stay in Baltimore (yrs., mos., or days) 24 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 McCulloh Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Drucilla Herbert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married-separated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23-1909

8. AGE: Years 37 | Months 1 | Days 15/16 | If less than one day hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Andrew Herbart
13. Birthplace South Carolina

MOTHER
14. Maiden Name Mariah Bolden
15. Birthplace South Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Anne Arundel Co. Md.

18 (a) Funeral director Wm. J. Chatman Jr.
(b) Address 1701 McCulloh St.

19 (a) (Date received by Local Registrar) (b) Registrar
FEB 10 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1947, at 3:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 8 1947, to Feb. 8 1947, and that I last saw h[illegible] alive on Feb. 8 1947.

| | Duration |
|---|---|
| Immediate cause of death Congestive Heart Failure | |
| Due to Patent Foramen Ovale | |
| Due to Adhesive Pericarditis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert R. Fowler M. D.
Address Balto. City Hosps. Date signed 2-8-47

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18398 BC# G62770

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 1190

Registered No. G18398

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 2½

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town 107 N Heston St
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christine M. McCarthy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 19 1946

8. AGE: Years - | Months 2½ | Days 19 | If less than one day hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Leo McCarthy
13. Birthplace Va

MOTHER 14. Maiden Name Adelaide Guidry
15. Birthplace Maryland

16 (a) Informant Adelaide Guidry
(b) Address 107 North Hilton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Edgar S Marshall
(b) Address Govans Md

19 (a) FEB 10 1947 (Date rec'd by registrar) (b)

Burial Permit Issued

VS 180

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1947, at 5-15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30 1947 to Feb 8 1947, and that I last saw him alive on Feb 8 1947

| Immediate cause of death | Duration |
|---|---|
| Cardio-respiratory failure | |
| Due to uraemitism | |
| Due to Gastro-enteritis | 10 days |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Farber M. D.
Address Bon Secours Hosp, Balto Date signed 2-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48399

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G48399 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs.) mos., or days) 4

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1263 E Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Eula Jones

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: W.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 64 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Fannie Powell
13. Birthplace N. C.

MOTHER
14. Maiden Name Nellie Smith
15. Birthplace N. C.

16 (a) Informant NATHAN Nathan Powell
(b) Address 1077 W Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn St
Location Balto City

18 (a) Funeral director Leonard L. Brown & Son
(b) Address 624 N Montgomery St

19 (a) FEB 10 1947 (Date received by Registrar) Huntington Williams M.D.

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 7 1947, at 2 P M

21. I certify that I took charge of the remains described above, held an Autopsy ~~Inquest~~ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Tuttle M.D. Medical Examiner.
Date signed 2-7-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48100

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

131a

G48100 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44 days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 703 Mt. Holly Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Dennis Anthony Dugan

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No. 215-09-4603

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Threasa A. Brannon
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1898

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 49 | 1 | 1 | hr. min. |

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual Occupation electrician
11. Industry or business

FATHER
12. Name John F. Dugan
13. Birthplace Brooklyn, New York

MOTHER
14. Maiden Name ? Towney
15. Birthplace Boston, Mass.

16 (a) Informant Records-U.S.Marine Hospital
(b) Address Baltimore 11, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director Geo. W. Little
(b) Address 2700 Edmondson Ave.

19 (a) (Date rec'd by Registrar) (b) Registrar

FEB 10 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 7 1947; at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 25 1946 to Feb. 7 1947, and that I last saw him alive on Feb. 7 1947.

| Immediate cause of death | Duration |
|---|---|
| Pneumonia, bronchial, all lobes | 1 week |
| Nephritis, chronic. | unknown |
| Cardiac hypertrophy, hypertension. | unknown |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy: As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis L Wilson M. D.
Address U. S. Marine Hospital Baltimore, Md. Date signed 2/8/47

G18101

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

G18101 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton St
(c) Hospital or institution: Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 120 Old Court Spring Lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Winnie Durham
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: W. H. Durham
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 8-21-77
8. AGE: Years 69 | Months 5 | Days 7 | If less than one day hr. min.
9. Birthplace Westminster Md (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER
12. Name Frank Mayer
13. Birthplace Westminster Md

MOTHER
14. Maiden Name Lena Stratter
15. Birthplace Balto Md

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-10-47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Adam Fleming Home Inc
(b) Address 403-6-25th St

19 (a) (Date rec'd by registrar) FEB 10 1947 Registrar Huntington Williams, MD

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7 1947 at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1946 to Feb 7 1947. and that I last saw h 64 alive on Feb. 6, 1947

Immediate cause of death: Myocardial Insufficiency — Duration 1 day
Due to: Arteriosclerosis
Due to:
Other Conditions: Bronchitis Nephritis (Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: None

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney D. Levy
Address 23 W Eutaw Pl Date signed 2/7/47 D

93E

C18102

AB-105177

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 30E

G18102 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mos.- 21days
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 122 West Hughes Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Joseph Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | Col. | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31-? ( 67?

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 ? | ? 5 | ? 2 | hr. 1879 min. |

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Peter Smith
13. Birthplace Pa.

MOTHER
14. Maiden Name Jamina
15. Birthplace W.Va.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Locat Johns Hopkins Medical School FEB 10 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 10 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2- 1947, at 3.35PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-11- 1946, to 2-2- 1947, and that I last saw h im alive on 2-2 1947

Immediate cause of death Respiratory Failure — Duration

Due to Cerebro-Vascular Accident. — 11 days

Due to ? Luetic C.V.D Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert K. Farber M. D.
Address Balto City Hosps. Date signed 2-2-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G48103 BGH G59612

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 119a

Registered No. G28103

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution: Bon Secours Hosp. 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 N. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Raymond Coates

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 2 | 23 | hr. min. |

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Edward Coates
13. Birthplace Ga.

MOTHER 14. Maiden Name Spencer Sawyer
15. Birthplace Balto. Md.

16 (a) Informant Edward Coates
(b) Address 1116 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-10-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Location Baltimore & Ridge Road

18 (a) Funeral director John C. Miller Jr.
(b) Address 2436 E. Oliver St

19 (a) (Permit to bury) (b) (Registrar)
FEB 10 1947 Huntington Hollins

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7 1947 at 11:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 30 1947 to Feb. 7 1947 and that I last saw him alive on Feb. 7 1947

Immediate cause of death: (a) Cardio-respiratory failure — Duration:
Due to: Exhaustion
Due to: Gastro-enteritis — 9 days
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in/about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Farber M. D.
Address Bon Secours Hosp, Balto Date 2-7-47

X

G48101 — 102831

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13B

Registered No. G48101

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-months 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 257 Colvin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** George Wallace

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9- 1906

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 40 | 3 | 26 | hr. min. |

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Wallace
13. Birthplace ?

MOTHER
14. Maiden Name Mary Kent
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records )

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/10/47 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bryant Lane

19 (a) (Date rec'd by registrar) (b) Registrar

VS FEB 10 1947 Huntington Hollins, M.D.

**MEDICAL CERTIFICATION** P M

20. DATE OF DEATH Feb. 5th 1947 19 , at 4.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 12th 1946 to Feb. 5th 1947, and that I last saw him alive on Feb. 5th 1947

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Tuberculosis | 3 years |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: C Conner

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H F Schaefer M. D.
Address Baltimore City Hospitals Date signed 2-6-47

X

G18105 ✓ G18105

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 92c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hospital for Women of Md

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3545 FIFTH ST
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Rose Agusta Crowl

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widow |

6 (b) Name of husband or wife Louis Crowl
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 1 | 25 | hr. min. |

9. Birthplace Baltimore, Baltimore Co, Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Gast
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Lex
15. Birthplace Germany

16 (a) Informant Deceased
(b) Address Same

17 (a) Burial (b) Date thereof 2/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd

18 (a) Funeral director Thos. F. Kenny Inc.
(b) Address 767 Light St

19 (a) FEB 10 (b) 1947
(Date received) Registrar

VS 8

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 6 Feb 1947 at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6 Feb 1947 to 6 Feb 1947 and that I last saw h.e.r alive on 6 Feb 1947.

| Immediate cause of death | Duration |
|---|---|
| Congestive Heart Failure | |
| Due to Chronic valvular heart disease | |
| Due to Rheumatic fever | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy: As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter Buckner M. D.
Address Women's Hospital Date signed 7 Feb 47

X

G48106

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 111a

✓ G48106 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yr.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3832 Brooklyn Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Arthur J Wageley

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | White | Widower |

6 (b) Name of husband or wife NYRTLE V. WAGELEY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1897

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 49 | 9 | 29 | hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Steel Worker
11. Industry or business Beth. Steel

FATHER
12. Name Thomas Wageley
13. Birthplace Maryland

MOTHER
14. Maiden Name Lydie Reyt
15. Birthplace Maryland

16 (a) Informant MRS. ELVA FANTASIE
(b) Address 3832 BROOKLYN AVE

17 (a) BURIAL (b) Date thereof 2 13 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location FREDERICK RD.

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST.

19 (a) (Date rec'd by Registrar) (b) 1947 Hunting [illegible] Md.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 9 1947, at 3:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21 1947 to Feb 9 1947, and that I last saw him alive on Feb 9 1947.

| Immediate cause of death | Duration |
|---|---|
| Acute Renal Insufficiency | One week |
| Due to Pulmonary Vein Thrombus | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Thrombus in Pulmonary Vein

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas M. Hutchins
Address South Balto. Gen. Hosp. Date signed 9 Feb. 1947
M D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 82a

G48107 ✓ G48107 Registered No.

G48107

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1223 N. Bond St.
(c) Hospital or institution: 8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1223 N. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** CARRIE MAUDE LAUGHERY

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife John H. Laughery
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 0 | 24 | hr. min. |

9. Birthplace Shippensburg, Pa.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Ephraim Wilson
13. Birthplace Pa.

MOTHER
14. Maiden Name Ida Fogle
15. Birthplace Pa.

16 (a) Informant Mr. John H. Laughery
(b) Address 1223 N. Bond St.

17 (a) Removal (b) Date thereof 2/10/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Shippensburg, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date received by Registrar) FEB 10 1947 Registrar Huntington Hillsdale, Md.

V S 150

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH Feb. 8, 1947 at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Feb 8 1947, and that I last saw h.. alive on Feb 7 1947

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Edema | |
| Due to Cerebral Hemm. | |
| Due to Arteriosclerosis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Ephraim M. D.
Address 443 E 25th St. Date signed 2-9-47

X

G18108 | BALTIMORE CITY HEALTH DEPARTMENT | G18108 Registered No.

# CERTIFICATE OF DEATH

X 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton St.
(c) Hospital or institution: Shriner Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Villa Nova (If outside city or town limits, write RURAL and give town)
(d) Street No. Essex Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** GRACE BELLE NORRIS

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1877

8. AGE: Years 70 | Months 0 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired School Teacher
11. Industry or business Balto. City

FATHER
12. Name William H. Norris
13. Birthplace Harford Co., Md.

MOTHER
14. Maiden Name Lydia Grey Dutton
15. Birthplace Baltimore, Md.

16 (a) Informant Rev. Thomas E. Copes
(b) Address 510 E. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Registrar

FEB 10 1947 Huntington Williams M.D.

V S 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 9, 1947, at 7:45 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2, 1947, to Feb. 9, 1947, and that I last saw her alive on Feb. 8, 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage & paralysis | 7 days |
| Due to | |
| Due to Advanced arteriosclerosis--? | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan Dubbett M. D.
Address 2220 Gaurnan Ave Date signed 2/10/47

X

G48109

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. G48109

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 15 W

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3406 Bateman Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Wm H. Masson

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| None | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Mar. 19, 1931

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 15 | 10 | 20 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Charles A. Masson
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Myra Turner
15. Birthplace Balto., Md.

16 (a) Informant Mr. Charles A. Masson
(b) Address 3406 Bateman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS FEB 10 1947

Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9 1947, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/5 1947, to 2/9 1947, and that I last saw him alive on 2/9 1947.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Bilateral empyema | |
| Due to Hemorrhage | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Pomeroy Judd M.D.
Address Ven. Hosp. Date signed 2/11/47

X

G48110 BALTIMORE CITY HEALTH DEPARTMENT G48110
CERTIFICATE OF DEATH 94a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution West Balto Steam Laundry

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give county)
(d) Street No. 1227 Poplar Grove St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Brucksch

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 212-07-5986

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Katherine E. Brucksch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23, 1882

8. AGE: Years 64 | Months 10 | Days 11/15 | If less than one day hr. min.

9. Birthplace Berlin, Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Leopold Brucksch
13. Birthplace Germany

MOTHER
14. Maiden Name Frederick Schultz
15. Birthplace Germany

16 (a) Informant Mrs. Katherine B. Brucksch
(b) Address 1227 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8th 1947, at 3:30 P M

21. I certify that I took charge of the remains described above, held an Aug Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Helfrich M.D. Medical Examiner.
Date signed Feb 8, 1947

VS 191

G48111

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

95B

Registered No. G48111

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Reyna Ave. & Dukeland St.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2609 Shirley Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mr. Paul Louis Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | 7 | 27 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Office Manager
11. Industry or business Meat Packing Co.

FATHER
12. Name James Louis Harris
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Ella Owens
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Grace Weidemann
(b) Address 2609 Shirley Ave.

17 (a) Burial (b) Date thereof 2/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 10 1947 (Date rec'd by registrar) (b) Pending for Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 7, 1947 at 9:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 9, 1947 to Feb. 7, 1947 and that I last saw him alive on Feb. 7, 1947

Immediate cause of death Cardiac failure — Duration

Due to Rheumatic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Rheumatic heart disease

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leon Toby M.D.
Address West Balto. Gen. Hosp. Date signed 2/8/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G18112 BCH G40241

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 1243

Registered No. G18112

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2422 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** WILLIAM C. SUTTON, JR.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | no |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 1 | 0 | 17 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William C. Sutton, Sr.
13. Birthplace Arnold, Md.

MOTHER
14. Maiden Name Grace Uhler
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. William C. Sutton, Sr.
(b) Address 2422 Linden Ave.

17 (a) Burial (b) Date thereof 2/12/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date received by registrar) Registrar

FEB 10 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9 1947, at 4:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/9 1947 to 2/9 1947, and that I last saw him alive on 2/9 1947

Immediate cause of death DEHYDRATION, ACIDOSIS — Duration 2 hrs.
BRONCHOPNEUMONIA

Due to

Due to

Other Conditions PREVIOUS GASTRO-INTESTINAL UPSET
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: MARKED DEHYDRATION, HEMORRHAGIC THYMUS, FATTY LIVER

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles W. Stewart, Jr. M. D.
Address Md. Gen. Hosp. Date signed 2-9-47

X

G48113

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93

Registered No. G48113

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland D.o.A
(b) Street address 2673 Eagle St
(c) Hospital or institution:
40
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2625 Eagle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Frank Reamer Sullivan

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 216-03-4462

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife: Anna Christine (nee Lorch)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 11 | 15 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Shipping Dept.

11. Industry or business Calvert Distillery

FATHER
12. Name Wesley Sullivan
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Annie Sophia Daugherty
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Anna C. Sullivan
(b) Address 2675 Eagle Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cemetery
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 10 1947 (Date rec'd by registrar) (b) [signature] Registrar

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**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/8 1947, at 12 20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive CeVdisease

Due to

Other Conditions Obesity

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 2/9/47

X

G48114

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13B

Registered No. G48114

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1246 W. Fairmount Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Robert) CLIFTON SMITH

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-18-0178

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1916

8. AGE: Years 30 | Months 4 | Days 29 | If less than one day hr. min.

9. Birthplace Norfolk Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William O Smith
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Fannie Epps
15. Birthplace Norfolk Va.

16 (a) Informant William O Smith
(b) Address 1015 Vincent St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 11 1947 (month) (day) (year)

(c) Cemetery or crematory Laurel Cem.
Location

18 (a) Funeral director Mrs Katie R. Gilliam
(b) Address 322 N. Schroeder St.

19 (a) (Date received by local registrar) FEB 10 1947 (b) Signature of local registrar Williams, M.D.

VS 181

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 7, 1947 at 3 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Intestinal obstruction, due to lymphegranuloma inguinale

Due to

Other Conditions Pulmonary tubereulosis, Congenital hypospadias
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 2/8/47

122 C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48115

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

$3a

Registered No. G48115

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2308 Annapolis Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2308 Annapolis Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Howard W. Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Col. | Married |

6 (b) Name of husband or wife Josephine Jackson (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug-12-1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 5 | 18 | 24 hr. min. |

9. Birthplace West Virginia
(City, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Curry Jackson
13. Birthplace West Virginia

MOTHER
14. Maiden Name Caroline (unknown)
15. Birthplace West Virginia

16 (a) Informant Josephine Jackson
(b) Address 2308 Annapolis Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 10, 1947 (month) (day) (year)
(c) Cemetery or crematory W. Auburn Ave
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 FEB 10 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH February-6- 1947, at 4.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from February 5-1947 to Feb-6-1947 and that I last saw h alive on February 6-1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | |
| Due to Hypertension | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter H. Sommerfeldt M. D.
Address 2708 Hollins Ferry Rd Date signed 2/6/47

G48116

509 418

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48a

G48116 Registered No.

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Stirling St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Annie Jones (Annie E. Jones)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-?-[illegible]

8. AGE: Years 54 | Months 9 | Days | If less than one day hr. min.

9. Birthplace md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name James Jones
13. Birthplace md.

MOTHER
14. Maiden Name Sarah 2.
15. Birthplace md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Feb. 10 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director Robert L. Young
(b) Address 1216 N. Carrollton Ave.

19 (a) 1947 (b)
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 6. 1947, at 10.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5. 1947 to Feb. 6 1947, and that I last saw h. alive on Feb. 6. 1947.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma cervix, extensive metastasis to chest, nodes & pelvis | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation 9.19.46

Major findings of operation: Biopsy lesions cervix, vulva, urethra

of autopsy Extensive carcinomatosis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. R. Novak

Address Johns Hopkins Hosp. Date signed 2.7.47 M. D.

VS 150 Huntington Williams, M.D.

X

G-8117

CHK-108290

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

108

Registered No. G-8117

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Min. (1 Hour)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County Roanoke
(c) City or town Baltimore Roanoke
(If outside city or town limits, write RURAL and give town)
(d) Street No. 678 Day Ave S.W. 218 E. Kenmore Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah E. Carter

3 (b) If veteran, name war

3 (c) Social Security Account No. UNKNOWN

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 23, 1869

8. AGE: Years 77 | Months 7 | Days 23 | If less than one day: 22 hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Francis F Cooper
13. Birthplace Warrenton Va

MOTHER
14. Maiden Name Mary O'Leary
15. Birthplace Alexander Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Avenue Roanoke Va

17 (a) Ship (Burial, cremation, or removal) (b) Date thereof Feb 10, 1947 (month) (day) (year)
(c) Cemetery or crematory ST Andrews
Location Roanoke, Roanoke Co. Va

18 (a) Funeral director Thomas W. Davidson
(b) Address Glen Burnie, Md

19 (a) FEB 10 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 1947, at 1:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 9 1947, to Feb. 9 1947, and that I last saw h... alive on Feb. 9 1947.

| | Duration |
|---|---|
| Immediate cause of death Coma | |
| Pneumonia | |
| Due to — | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert R. Fowler M. D.
Address Balto City Hosps Date signed 2-9-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G48118 CWK-100924

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G48118 107

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9m 9m
(e) Length of stay in Baltimore (yrs., mos., or days) 47 Yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Smithson Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Henry Fletcher Phillips

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Widower |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1-1[illegible]

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 | 7 | 7 | hr. min. |

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Phillips
13. Birthplace Virginia

MOTHER
14. Maiden Name Susan Chandler
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Wed. D. Kelson
(b) Address 1303 Pennsylvania Ave

(Date received by registrar) (b) Registrar

VS 190

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1947, at 1:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 29 19 46 to Feb. 8 19 47 and that I last saw h[illegible] alive on Feb. 8 19 47

| Immediate cause of death | Duration |
|---|---|
| Lung Abscess - Right. | 1 yr. |
| Bronchopneumonia | 1 Day |
| Due to | |
| Due to | |
| Other Conditions Dilatation of Aorta with obstruction of Esophagus | over |

(Include pregnancy within 3 months of death)
Date of operation 2-7-47
Major findings of operation: Contracted stomach
of autopsy: Absent

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Maurice M. Lacy M. D.
Address Baltimore City Hospitals Date signed 2-8-47

G48119

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

93E

G48119 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1430 Presstman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Sampson Tolson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lola Tolson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-19-02.

8. AGE: Years 44 | Months 7 | Days 18 | If less than one day hr. min.

9. Birthplace Virginia (Town, county and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Joseph Tolson
13. Birthplace Virginia

MOTHER
14. Maiden Name Martha Washington
15. Birthplace Virginia

16 (a) Informant Lola Tolson
(b) Address 1430 Presstman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/47 (month) (day) (year)
(c) Cemetery or crematory Kalmarock,
Location Kalmarock, Va

18 (a) Funeral director Geo. M. Kelson
(b) Address 1303 Pressman St

19 (a) (b) Registrar
(Date rec'd by registrar)

B 0 194
VS 150

Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7, 1947, at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-7 1947, to 2-7 1947, and that I last saw him alive on 2-7 1947.

| | Duration |
|---|---|
| Immediate cause of death Cardiac failure | 2 yrs |
| Due to Myocarditis | 2 yrs |
| Due to unknown cause | |
| Other Conditions Uremia | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. J. Dubois M. D.
Address Johns Hopkins Hospital Date signed 2-7-47

X

G48120

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G48120 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street city
(c) Hospital or institution:
Sisters of the Poor 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 77 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** Minnie Cross

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | white | Widowed |

6 (b) Name of husband or wife George W. Cross
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1862

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 84 | 6 mo. | 22 | hr. min. |

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Fredricke Behringer
13. Birthplace Germany

MOTHER 14. Maiden Name Johanna ?
15. Birthplace Germany

16 (a) Informant Sister Superior
(b) Address 1200 Valley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-10-47 (month) (day) (year)
(c) Cemetery or crematory Int Evangelical Cem
Location Baltimore, Md.

18 (a) Funeral director Henry Sanders Sons Inc
(b) Address Park Ave & Pine Lane Huntington Station, Md.
(c) (b)

FEB 10 1947 (Date rec'd by registrar) Registrar

VS 8

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb-7- 1947, at 2:15 PM

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 7- 1947, to Feb 7- 1947, and that I last saw her alive on Feb 7 1947

| Immediate cause of death | Duration |
|---|---|
| Edema Lungs- | 1 day |
| Due to Chronic myocarditis | 3 yrs |
| Due to | |
| Other Conditions Cutenis Sclerosis | 10 yrs |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Av Date signed 2/8/47

X

G48121

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G48121 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Rayner ave. & Oakland St.
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3404 Dillon St. - 24
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Annie M. Inscoe (annie May Inscoe)

3 (b) If veteran, name war: No.
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Irving Inscoe
6 (c) If wife, give age 68 years
7. Birth date of deceased (mo., day, yr.) May 25 1883
8. AGE: Years 63 Months 8 Days 13 If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Kershner
13. Birthplace Penna.

MOTHER
14. Maiden Name Minnie Harbold
15. Birthplace Penna.

16 (a) Informant Mr. Irving Inscoe
(b) Address 3404 Dillon St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-11-47 (month) (day) (year)
(c) Cemetery or crematory Westerns Cemetery
Location Baltimore, Md.

18 (a) Funeral director Henry Sandra Sons
(b) Address North Ave & Broadway
(c) FEB 10 1947 (Date rec'd by registrar) Clayton Williams Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 7, 1947 at 9:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1947 to Feb 7 1947 and that I last saw h[illegible] alive on Feb 7, 1947 5 PM → 9:50 PM

Immediate cause of death: Respiratory failure — Duration

Due to Pneumococcic Meningitis and Brain abscess

Due to Otitis media, rt. ear

Other Conditions Diabetes mellitus, Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Meningitis, Brain abscess

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leon Toby M.D.
Address West Balto. Gen. Hosp. Date signed 2/8/47

89a

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48122 — 46E — (illegible)

Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2687 Dulaney ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2687 Dulaney ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles J Zeches

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| World War I | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 3 | 29 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Shipfitter's Helper
11. Industry or business Gas + Elec. Co.

FATHER
12. Name John Zeches
13. Birthplace Germany

MOTHER
14. Maiden Name Emily Fischer
15. Birthplace Germany

16 (a) Informant Mrs Lillian Zeches
(b) Address 2687 Dulaney St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 11 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd

18 (a) Funeral director Henry H Withe
(b) Address 4101 Elbamonan Ave

19 (a) 2-10-1947 (Date rec'd by Registrar) (b) Jos Hollinger, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 7 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1946 to Feb 7 1947
and that I last saw him alive on Feb. 5 1947 1947

| Immediate cause of death | Duration |
|---|---|
| carcinomatosis | |
| Due to carcinoma upper portion of descending | 1 year |
| Due to colon | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan Rasmin M.D.
Address 206 S. Gilmor St Date signed 2-7-47

VS 150

X

G48123

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48123 Registered No. 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 624 Calvaire Rd
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 624 Calvaire Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Harriet Brazier

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Married (Sup.)

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 29 June, 1883

8. AGE: Years 63 64 | Months 7 | Days 8 9 | If less than one day hr. min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER 12. Name Edward Holden

13. Birthplace England

MOTHER 14. Maiden Name Harriet Ezell Thrift

15. Birthplace England

16 (a) Informant Mr. Robert B. Holden

(b) Address 624 Calvaire Rd

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Feb. 10 1947 (month) (day) (year)

(c) Cemetery or crematory London Park

Location 3811 Frederick Rd

18 (a) Funeral director Henry H. Wight

(b) Address 4101 Edmondson Ave

19 (a) Filed by (Signature) Livingston Williams, Registrar

FEB 10 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1947 at 3:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2 1947 to Feb 8 1947 and that I last saw her alive on Feb. 7 1947.

| Immediate cause of death | Duration |
|---|---|
| Circulatory Failure | |
| Due to | |
| Due to | |
| Other Conditions Bronchopneumonia | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward F. Burkhart

Address Maryland Gen'l Hosp Date signed Feb 8, 1947

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48124

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 878

G48124 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address CALVERT & SARATOGA.
(c) Hospital or institution:
MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 41
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County
(c) City or town BALT.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 ROCK GLENN RD.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** FRANK McFARLAND

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | MARRIED |

6 (b) Name of husband or wife Zellie (Reuben)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 10 (1882) 1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 (53rd) | 7 | 28 | hr. min. |

9. Birthplace BALT.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name FRANK McFARLAND
13. Birthplace MD.

MOTHER
14. Maiden Name MOLLIE GRUNDINE
15. Birthplace MD.

16 (a) Informant Mrs Zellie McFarland
(b) Address 412 Rock Glenn Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 11 '47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Harry W. Taylor
(b) Address 4101 Edmondson Ave

19 (a) Date received by registrar FEB 12 1947 (b) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2-8 1947, at 9:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-28 1946, to 2-8 1947, and that I last saw him alive on 2-8 1947.

| | Duration |
|---|---|
| Immediate cause of death RESPIRATORY FAILURE. | |
| Due to ENC. INTRACRANIAL PRESSURE. | |
| Due to SPACE-OCCUPYING MASS RT. PARIETAL OCC. REGION BRAIN | |
| Other Conditions HYPERTENSION COMPLETE BLINDNESS (Include pregnancy within 3 months of death) | |
| Date of operation 1-2-47. | |
| Major findings of operation: | |
| of autopsy: | |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James A. Roberts M. D.
Address Mercy Hospital Date signed 2-8-47

VS 150

G18125

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G18125 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2243 E Preston
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2243 E. Preston
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** - Michael Fleischmann

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-8296

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Widowed |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18th 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 73 | 9 | 19 | hr. min. |

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Cabinet Maker
11. Industry or business Beds Inc

FATHER
12. Name John Fleischmann
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Mr Fleischmann
(b) Address 2243 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 11th 1937 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Leo E. Brook
(b) Address 1201-03 N. Patterson Park Ave

19 (a) (b)
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

FEB 10 1937

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/7/47 19 , at 9:15 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Hos death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis, Medical Examiner M.D.
Date signed 2/8/47

X

G48126

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 97

G48126 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4218 La Sale Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 6
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4218 La Sale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Annie Keene

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 9th 1867

8. AGE: Years 79 | Months 80 | Days 6 | If less than one day hr. min. — 

9. Birthplace York Pa (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Herman
13. Birthplace Germany.

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Mrs Keene
(b) Address 4218 La Sale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo S. Lesnick
(b) Address 1701-03 N. Patterson Park ave

19 (a) Filed FEB 10 1947 (Date rec'd by registrar) Huntington Williams, Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2-9th 1947, at 930 A M

21. I certify that death occurred on the date above stated; that I attended deceased from APRIL 6 1946 to FEB 9 1947, and that I last saw h[illegible] alive on FEB 3 1947

| Immediate cause of death | Duration |
|---|---|
| ARTERIOSCLEROSIS | ? |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Victor Gallberg M.D.
Address 3400 Harford Road Date signed Feb 10 1947

VS 150

CWK-10880 G48127

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

81a

G48127
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Anne Arundel
(c) City or town Baltimore & Elvation, Md.
Elveton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (if rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Dora Ann Hudson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married-Separated

6 (b) Name of husband or wife: George Hudson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 15-1882

8. AGE: Years 64 | Months 11 | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Branford
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Cager
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof Feb 12-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory 1st Baptist Cemetery
Location Catalpa Keighton Md

18 (a) Funeral director J. B. Johnson
(b) Address Annapolis Md.

19 (a) FEB 20 1947
(Date rec'd by registrar) Washington Williams, Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1947, at 11:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7 19 47, to Feb. 8 19 47 and that I last saw h. alive on Feb. 8 19 47.

| Immediate cause of death | Duration |
|---|---|
| Meningitis, Pneumococcic | 2 days. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund Beaelam M.D.
M. D.
Address Balto City Hosp Date signed 10 Feb 47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G13128

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G13128

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2305 Reisterstown Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2305 Reisterstown Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence G. Allbutt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11 - 1881

| 8. AGE: | Years | Months | Days | If less than one day |
|---|---|---|---|---|
| | 65 | 8 | 27 | hr. min. |

9. Birthplace Paisley Scotland
(Town, county, and state)
10. Usual Occupation Bookkeeper for
11. Industry or business Armstrong & Cray

FATHER
12. Name George L. Allbutt
13. Birthplace England

MOTHER
14. Maiden Name Julia Gunton
15. Birthplace England

16 (a) Informant Rev. George C. Allbutt
(b) Address 2300 Reisterstown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 6 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon
Location Baltimore

18 (a) Funeral director Symmes Oak Ryder
(b) Address 1600 N. North Ave

19 (a) (Date received by registrar) (b) Registrar

FEB 10 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1947, at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1946, to Feb 8 1947, and that I last saw him alive on Feb 7 1947.

Immediate cause of death: Coronary heart disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. H. Patterson M. D.
Address 2324 Reisterstown Rd Date signed 2/8/47

Birth Certificate

G48129 J.70191

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 158

G48129

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address City Hospital
(c) Hospital or institution: City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Bolto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5005 Reisterstown Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Gwyn Lee Malone

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| — | — |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | S |

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2/4/47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| — | — | 5 | — hr. — min. |

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation —
11. Industry or business

FATHER
12. Name George T. J. Malone
13. Birthplace West Virginia

MOTHER
14. Maiden Name Emma J. Malone
15. Birthplace West Virginia

16 (a) Informant — Mother
(b) Address 5005 Reisterstown Rd

17 (a) Burial (b) Date thereof Feb 10-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Saint Johns
Location Ellicott City, Md.

18 (a) Funeral director Ellsworth Arrangod
(b) Address 3911 Liberty Heights Ave

19 (a) FEB 10 1947 Baltimore, Md.
(Date received by registrar) (Registrar)

VS 2

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1947, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1947, to Feb 9 1947, and that I last saw him alive on Feb 8 1947.

| Immediate cause of death | Duration |
|---|---|
| Unknown, Weak on Coming from Hospital (Jaundice) | |
| Due to Thus & the 13th Child of | |
| Due to that Mother had it was apparently very Weak Baby | |
| Other Conditions (Weight 6 lbs) | |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Charles L Wells M. D.
Address 576 Park Ave Date signed Feb 9 47

X

G48130

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G48130 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 334 Maude Ave.
(a) Baltimore City, Maryland
(b) Street address 334 Maude Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 334 Maude Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Everett Smith

3 (b) If veteran, name war: World War. 1-
3 (c) Social Security Account No. 216-15-9356

4. Sex: Male
5. Color or race: White
6 (a) ~~Single~~, married, ~~widowed, or divorced~~: married.
6 (b) Name of husband or wife: Irene E. Smith
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) May 28, 1895

8. AGE: Years 51 | Months 8 | Days 12 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Shipping Clerk
11. Industry or business Westinghouse Mfg. Co.

FATHER
12. Name George Smith
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Emma Weineke
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Irene E. Smith
(b) Address 334 Maude Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12, 1947 (month) (day) (year)
(c) Cemetery or crematory U.S. National
Location Balto. Md.

18 (a) Funeral director George Weber & Son.
(b) Address 2503 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1947, at 8P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1946 to Feb 9 1947
and that I last saw h[illegible] alive on Feb 9 1947

| Immediate cause of death | Duration |
|---|---|
| Coronary occlusion | |
| Due to Hypertension | |
| Due to Cardio vascular | |
| Other Conditions Cirrhosis of Liver | |
| (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 302 Talbot Ave Date signed 2-10-47

VS FEB 10 1947 Huntington Williams, M.D.

X

# STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH ~~C18131~~ ~~3 [illegible] Ave~~ Old Hartford Rd. / 50 C18131
County ~~C18131~~ Registration Dist. No.
Village or City Baltimore No. Beech Hill Nursing Home Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)
Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Emma V. Lutz
(a) Residence: No. 3734 Old York Road St. Ward.
(Usual place of abode) If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) |
|---|---|---|
| Female | white | widowed |

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of William J. Lutz

6. DATE OF BIRTH (month, day, and year) Feb. 22-1867

| 7. AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 79 | 11 | 17 | 16 |

OCCUPATION
8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. at home
9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Baltimore, Md
(State or country)

FATHER
13. NAME Henry Clay Beard
14. BIRTHPLACE (city or town) Md.
(State or country)

MOTHER
15. MAIDEN NAME Lavina Evans
16. BIRTHPLACE (city or town) Md
(State or country)

17. INFORMANT Mrs. J. Louis Faudorf
(Address) 4706 Arkansas Ave

18. BURIAL CREMATION, OR REMOVAL
Place Loudon Pk. Date Feb. 19 47

19. UNDERTAKER Leonard J. Ryck
(Address) 5305 Raffold Road

20. FILED , 19

FEB 10 1947 [illegible] Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Feb. (Month) 8 (Day) 1947 (Year)

22. I HEREBY CERTIFY, That I attended deceased from June 1938, to 8 Feb 1947
I last saw h.er alive on 2 Feb, 1947; death is said to have occurred on the date stated above, at 6 A. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Bronchio Pneumonia | 1 Feb 47 |
| | |
| | |
| | |
| Other Contributory Causes of importance: Carcinoma of Breast with metastasis to Chest | 1946 |
| | |

Name of operation None Date of
What test confirmed diagnosis? Clinical Obs. Was there an autopsy? No.

23. If death was due to external causes (VIOLENCE) fill in also the following:
Accident, suicide, or homicide? Date of injury , 19
Where did injury occur? (Specify city or town, county and State)
Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No.
If so, specify
(Signed) Charles St. Keen M. D.
(Address) 6701 York Rd Balto 12 Md.

CAUSES OF DEATH should be stated in plain terms, so that the meaning may be clear to persons not acquainted with technical terms. Indefinite and unsatisfactory terms, such as "Debility," "Old Age," "Senility," "Exhaustion," "Cardiac Failure," "Heart Failure," "Kidney Trouble," "Uremia," "Convulsions," "Hemorrhage," "Blood Poisoning," "Septicemia," "Pyemia," "Tumor," "Cancer," "Abscess," "Paralysis," "Meningitis," "Inflammation," "Fever," "Spasm," "Stroke," "Shock," "Coma," "Internal Injuries," "Burns," "Wounds," "Fracture," "Accident," "Drowning," "Found Dead," "Homicide," "Suicide," "Execution," "Lockjaw," "Malpractice," "Unknown," "Supposed," "Probable," "Apparent," "Presumed," "Whole Time," "Duration," "Chronic," "Acute," "Complications," "Sudden," "Instantaneous," "Unavoidable," "Natural Causes," "Multiple Causes," "Contributory Causes," "Secondary Causes," "Immediate Cause," "Primary Cause," "Final Cause," "Ultimate Cause," "Intermediate Cause," "Mechanical Cause," "Physical Cause," "Medical Cause," "Legal Cause," "Morbid Conditions," "Morbid Anatomical Changes," "Morbid Histological Changes," "Pathological Conditions," "Pathological Changes," "Pathological Lesions," "Pathological Diagnosis," "Clinical Diagnosis," "Diagnosis Unconfirmed," "Diagnosis Confirmed," "Diagnosis Verified," "Diagnosis Corroborated," "Diagnosis Substantiated," "Diagnosis Established," "Diagnosis Proved," "Diagnosis Demonstrated," "Diagnosis Shown," "Diagnosis Indicated," "Diagnosis Suggested," "Diagnosis Suspected," "Diagnosis Presumed," "Diagnosis Probable," "Diagnosis Apparent," "Diagnosis Unknown," "Diagnosis Supposed," "Diagnosis Doubtful," "Diagnosis Questionable," "Diagnosis Uncertain," "Diagnosis Indefinite," "Diagnosis Unsatisfactory," "Diagnosis Inconclusive," "Diagnosis Undetermined," "Diagnosis Undecided," "Diagnosis Undefined," "Diagnosis Unspecified," "Diagnosis Unclassified," "Diagnosis Unclassifiable," "Diagnosis Unclassifiable," "Diagnosis Unclassifiable

Dr. Fearing
3025 Belair Road

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 467

Registered No. C18132

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3020 Brendan Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3020 Brendan Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mamie A. Spohr

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widowed |

6 (b) Name of husband or wife John E. Spohr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 0 | 8 | hr. min. |

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Stephen Braff
13. Birthplace Md.

MOTHER
14. Maiden Name Amma Himmel
15. Birthplace Md.

16 (a) Informant Mrs. Matthew C. Butta
(b) Address 3020 Brendan Avenue

17 (a) Burial (b) Date thereof 2/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oaklawn Mem.
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (d) FEB 10 1947 Huntingtown, Md.
(Date received by registrar) (Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 8, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1946 to 2-8 1947.
and that I last saw h[illegible] alive on 2-7 1947.

Immediate cause of death: Cardiac Failure — Duration: 1 day
Due to: Adenocarcinoma of Recto-Sigmoid — 8 Mo.
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation 14 Sept 1946
Major findings of operation: Adenocarcinoma of Rectum
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilbur L. Fearing
Address 3025 Belair Rd Date signed 2-8-47

VS 150

X

G48133

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

G48133

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address ...
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) ...

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County ...
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 4911 Pilgrim Rd (If rural give location)
(e) Citizen of foreign country? ... (Yes or No)
If yes, name country ...

**3 (a) FULL NAME** George E Stortz

3 (b) If veteran, name war ...

3 (c) Social Security Account No. ...

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife Rosa C.

6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Sept. 22-1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 4 | 17 | ... hr. ... min. |

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business ...

FATHER
12. Name Emil Storatz
13. Birthplace ✓

MOTHER
14. Maiden Name ...
15. Birthplace ✓

16 (a) Informant Mr. Irving C. Stortz
(b) Address 809 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/47 (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard Luck
(b) Address 5305 Harford Rd.

19 (a) ... (Date rec'd by registrar) (b) ... Registrar
Huntington Williams

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 2/8 1947 at 11:30 A.M.

**21.** I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to ...

Other Conditions ...

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ... at ... M.

(b) Where did injury occur? ...

(c) Did injury occur at home, on farm, industrial place, in public place? ... While at work? ...

(d) Means of injury ...

23. Signature C. J. Tsibrikis M.D. Medical Examiner.

Date signed 2/9/47

EB VS (3) 1947

G48134

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G48134 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5506 Morell, Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5506 Morellc Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Josephine Crumbacker

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widowed |

6 (b) Name of husband or wife John E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1869

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 1 | 8 | hr. min. |

9. Birthplace Carroll County, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Samuel Cook
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Helen C. Krummer
(b) Address 5506 Morello Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/47 (month) (day) (year)
(c) Cemetery or crematory Pipe Creek Cem.
Location Maryland

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 14 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Febl 10. 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to 2/10 1947 and that I last saw h[illegible] alive on 2/10 1947

| Immediate cause of death | Duration |
|---|---|
| Hemorrhage Cardio-Vascular Renal | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Over Tolley M. D.
Address 5203 Harford Rd Date signed 2/14/47

Huntington Hollins M.D.

X

G48135

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46E

G48135 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4204 Reisterstown Rd.
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore City
(c) City or town 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4204 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anna M. Madden

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Martin J. Madden
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 16, 1909

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 37 | 10 | 21 | hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at home

FATHER
12. Name Robert C. Frisby
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name A. Matula
15. Birthplace Baltimore City

16 (a) Informant Mrs. Chas. A. Paff
(b) Address 4204 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-10-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Le Vernon Lemmon
(b) Address 4611 Park Heights Ave.,

19 (a) (Date received by registrar) (b) Registrar

FEB 10 1947

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7th 1947, at 10:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 1947 to 2/7 1947, and that I last saw her alive on 2/6 1947

| Important cause of death | Duration |
|---|---|
| Pulmonary Edema | 1 Day |
| Due to Carcinoma of Bladder | |
| Due to Carcinoma of Sigmoid | |
| Other Conditions Generalized Metastasis | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James A. Lichtenberger
Address 711 Medical Arts Bldg. Date signed 2/9/47

Duge

# HEALTH DEPARTMENT—CITY OF BALTIMORE

G48136 CERTIFICATE OF DEATH 194a G48136

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 5502 Belle Vista Ave St., 14 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Adolph William Duge

If U.S. Veteran specify WAR

(a) Residence: No. 5602 Belle Vista Ave St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. Color or Race | 5. Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| M | W | M |

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy Duge

6. DATE OF BIRTH (month, day, year) May 25-1883

| 7. AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 63 | 8 | 14 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. machinist

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Continental Can.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Germany

FATHER

13. NAME William Duge

14. BIRTHPLACE (city or town) (State or country) Germany

MOTHER

15. MAIDEN NAME Caroline

16. BIRTHPLACE (city or town) (State or country) Germany

17. INFORMANT Mrs. Lucy Duge

(Address) 5502 Belle Vista Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Parkwood Date 2/12 1947

19. UNDERTAKER Leonard J. Kyck

(Address) 530 S Haufax Road

20. FEB 10 1947 Registrar

Huntington Hillsmeyer

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 2/8 1947

22. I HEREBY CERTIFY, That I attended deceased from 2/6/47, 19 to 2/8/47, 19

I last saw h 1m alive on 2/8/47, 19 Death is said to have occurred on the date stated above, at 6:25 P m.

The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Coronary Occlusion | 2/6/47 |
| Pulmonary Edema | 2/6/47 |

Other contributory causes of importance:

Was an operation performed? — Date of

For what disease or injury?

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Walter E. Kaylor, M. D.

(Address) 4331 Hayford Rd.

X

informed of the following requirements of the law: Every death must be reported to the Health Department within 24 hours after death occurs. Exact statement of state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

VS 3

G48137
506004

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 74a

G48137
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State N.Y. (b) County
(c) City or town New York.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 277 W 150th St. apt no -19
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Marie Bowers

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Black | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-17-40

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 6 | 9 | 20 | hr. min. |

9. Birthplace N.Y. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Singleteary
13. Birthplace Ga.

MOTHER
14. Maiden Name Estelle Singleteary
15. Birthplace Va.

16 (a) Informant Friends.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof Feb 10/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Chatham Va.

18 (a) Funeral director Mrs Lotta Elliott Dy
(b) Address 1129 N. Caroline st.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 10 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH Feb-7 1947, at 8:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-8 1946 to Feb-7 1947 and that I last saw h[illegible] alive on Feb-7 1947.

| Immediate cause of death | Duration |
|---|---|
| Broncho pneumonia | 3 days |
| Due to Leukemia, Lympho-Cytic | 3 mo. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gilbert J. Sheldon
Address Date signed

G48138
507840

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH ✓ 82

Registered No. G48138

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 E. Monument St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** James Smith.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male. | Negro. | single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-28-29.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 17. | 6 | 10 | hr. min. |

9. Birthplace Balto, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Smith
13. Birthplace 2.

MOTHER
14. Maiden Name Lucy Harris
15. Birthplace Va

16 (a) Informant Rosenda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore, Maryland

18 (a) Funeral director Macabe Bibley
(b) Address 1421 E. Jefferson St

19 (a) (Date rec'd by registrar) FEB 10 1947 (b)

VS

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb 7 1947, at 7.10 P. M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan - 10 1947. to Feb - 7 1947. and that I last saw him alive on Feb - 7 1947.

| Immediate cause of death | Duration |
|---|---|
| Increased Intracranial Pressure. | 2 days |
| Due to Syringomyelia | 3 mos. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation Feb 1947.

Major findings of operation: Increased Intracranial Pressure

of autopsy: Syringomyelia.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur M. Long M. D.
Address John Hopkins Hosp. Date signed 2/7/47

X

G48139

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 183

Registered No. G48139

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Da
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 S. East Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** George H. Meyers

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | M |

6 (b) Name of husband or wife Matilda Meyers
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) May 23 1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 8 | 15 | ....hr. ....min. |

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Guard
11. Industry or business Marine Commission

FATHER
12. Name Geo H Meyers
13. Birthplace Balto

MOTHER
14. Maiden Name Annie Steinbrick
15. Birthplace Balto

16 (a) Informant Matilda Meyers
(b) Address 12 S East Ave

17 (a) Burial (b) Date thereof Feby 11
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2018 Orleans St

19 (a) (Date rec'd by local reg.) 2-8-47 (b) Huntington-Williams, Inc.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7th 1947 at 8:38 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-7-47 at approx 12 7 P.M.?
(b) Where did injury occur? S.S. Explorer, Locust Point
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury Fell from gang-plank into harbor

23. Signature Howard J. Devilbiss M.D.
Medical Examiner.
Date signed 2-8-47

VS 181

G48140

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 1176

Registered No. G48140

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Halthorpe - 27
(If outside city or town limits, write RURAL and give town)
(d) Street No. Woodside Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Maurice Kilditch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, (widowed), or divorced.

6 (b) Name of husband or wife Clara —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1852

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Dont Know
13. Birthplace

MOTHER
14. Maiden Name Dont Know
15. Birthplace

16 (a) Informant Chas Yeager
(b) Address 2101 N Kenwood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Co Md

18 (a) Funeral director Wm L Frank Hoy
(b) Address 2008 Orleans St

19 (a) (Date rec'd by registrar) 10 1947 Registrar Williams M.D.

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 2/8 1947, at 9 PM

**21.** I certify that death occurred on the date above stated; that I attended deceased from 1-22 1947, to 2-8 1947, and that I last saw him alive on 2-8 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | — |
| Due to Hypertension C.V.D. | |
| Due to | |
| Other Conditions Post Op. Gastroenterostomy for Peptic Ulcer; Bilat. Hernias | |

(Include pregnancy within 3 months of death)

Date of operation 1-25-47

Major findings of operation: Duodenal Ulcer.

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23.** Signature Guy K Higgs M.D.
Address Hoen Bldg Date signed 2-9-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Birth Certificate
G-18111
D-90678

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 158

G18111
Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 9
(c) Hospital or institution: Bon Secours Hosp 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Bon Secours Hosp (If rural give location) 3912 Foster Ave
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Gentile (boy)

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/9/47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 1 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John A Gentile
13. Birthplace Balto

MOTHER 14. Maiden Name Marguerite A Bontrom
15. Birthplace Balto

16 (a) Informant Mrs Dean
(b) Address 2608 Mt Fairmount

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 13 (month) (day) (year)
(c) Cemetery or crematory Dolf Haven City
Location

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2005 Orleans St

19 (a) FEB 10 1947 (Date received by registrar) Huntington Williams, Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1947 at 10 35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9 1947 to Feb 10 1947 and that I last saw h alive on Feb 10 1947

| Immediate cause of death | Duration |
|---|---|
| Respiratory paralysis | |
| Due to Cerebral amyloidosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William E Kerr M. D.
Address Bon Secours Hosp Date signed 2/10/47

VS 150

X

G18112

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13B

R G18112

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3529 E Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3529 E Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Andrew H. Russell

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-03-7312

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Divorced |

6 (b) Name of husband or wife Annie Russell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 16 1897

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 49 | 9 | 21 | hr. min. |

9. Birthplace Scotland (town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Ed Gludenberger Kurdle

FATHER — 12. Name Robt Russell
13. Birthplace Scotland

MOTHER — 14. Maiden Name Elizabeth Brighton
15. Birthplace Scotland

16 (a) Informant Mrs James Adams
(b) Address 3320 Lauriver Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 10th (month) (day) (year)
(c) Cemetery or crematory Woodland Memorial Park
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

FEB 10 1947

VS 50

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feby 7th 19 47, at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/3 1947 to 2/7 1947, and that I last saw h[illegible] alive on 2/7 1947.

Immediate cause of death [illegible] Pulmonary T.B.
Due to [illegible]
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Williams

Address 3400 E Baltimore Date signed 2/8/47 (M. D.)

X

G48113

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 45B

Registered No. G48113

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 720 N. Streeper St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 720 N Streeper St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Helen Koenig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Otto Koenig

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Oct 26 1902

8. AGE: Years 44 | Months 3 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER 12. Name Herman Weske

13. Birthplace Germany

MOTHER 14. Maiden Name Clara Hoffstein

15. Birthplace Germany

16 (a) Informant Otto Koenig

(b) Address 720 N Streeper St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 10th (month) (day) (year)

(c) Cemetery or crematory London Park

Location City

18 (a) Funeral director Ullrich Funeral Home

(b) Address 2008 Orleans St

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

FEB 10 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1947, at 12.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2- 1947 to 2-6- 1947 and that I last saw h[illegible] alive on 2-6 1947

Immediate cause of death CARCINOMA (TONGUE) — Duration 1 YR

Due to METASTASIS TO NECK + CHEST

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James J Kavanaugh M.D.

Address 3614 McElderry Date signed 2-8-47

M. D.

G48144

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1477

G48144 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3902 Foster Ave
(c) Hospital or institution: Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3902 Foster Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Marguerite Gentile S70648

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John H. Gentile

6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) Aug 29 1918

8. AGE: Years 28 | Months 5 | Days 11 | If less than one day: hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business Ft Howard

FATHER
12. Name John Fontrone
13. Birthplace Balto

MOTHER
14. Maiden Name Dont know
15. Birthplace Baltimore

16 (a) Informant Mrs Deans
(b) Address 2208 N. Fauquier Ave

17 (a) Ca Burial (b) Date thereof Feby 13
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory O & L Farm
Location Catonsville

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2006 Orleans St

19 (a) (b) Hastings Williamsville

FEB 10 1947

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb 9 1947, at 9 45 F M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Feb 9 1947, to Feb 9 1947, and that I last saw [illegible] alive on Feb 9 1947

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Embolism | Sudden |
| Due to Pregnancy at term | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E. Farber
Address Bon Secours Hosp, Balto Date signed M 2 D 9 Y 47

X

G18145

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G18145

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2251 E. Chase St.
(c) Hospital or institution: 8-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2251 E. Chase St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3. (a) FULL NAME** MAMIE M. KOERNER

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widowed |

6 (b) Name of husband or wife George F. Koerner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 24, 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 yrs. | 5 | 13 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John A. Hergenrother
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Barbara Yeakel
15. Birthplace Germany

16 (a) Informant Fred Hergenrother - brother
(b) Address 2429 E. Madison St.

17 (a) Burial (b) Date thereof 2/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison St.

19 (a) (Date received) FEB 10 1947 Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 1947 at 9:18 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1947 to Feb 6 1947.
and that I last saw him alive on Feb 6 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | 2 days |
| Due to Chr. Myocarditis | 1 year |
| Due to Hypertensive Cardio-vascular disease | 1 year |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Rytauer, M.D.
Address 801 Lockwood Rd. Date signed 2/10/47

X

G48146

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G48146 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4719 Hazelwood Ave.
(c) Hospital or institution: 6 V

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4719 Hazelwood Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Alice Irene Mitchberg

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: John
6 (c) If alive, give age 61 years
7. Birth date of deceased (mo., day, yr.) July 12, 1891
8. AGE: Years 55 | Months 6 | Days 26 | If less than one day: hr. min.
9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name William Keller
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Emma Spinks
15. Birthplace Baltimore, Md.

16 (a) Informant John Mitchberg
(b) Address 4719 Hazelwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Rd.

18 (a) Funeral director M. W. E. Dupper & Sons
(b) Address 5110 Belair Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

vs FEB 10 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8th 1947, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1 1946 to Feb 8 1947 and that I last saw her alive on 2-7 1947

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | 2 hours. |
| Due to Cardiovascular Disease | 5 yrs. |
| Due to | |
| Other Conditions Hypertension | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Max R. English M. D.
Address 5713 Belair Rd Date signed 2-8-47

X

G48147

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 63c

G48147 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write distinctly and legibly. Cite the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland ✓
(b) Street address 3 E. CALVERT AND SARATOGA
(c) Hospital or institution:
MERCY HOSPITAL ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD ✓ (b) County —
(c) City or town BALT.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 35 S. ANN ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MRS. LOUISA HARRIGAN

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| NO | 60HC |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | WIDOW |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | | 21 | hr. min. |

9. Birthplace BALT. MD.
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name — ZANONE
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/13/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director M. W. E. Dipple & Sons
(b) Address Lombard & Ann Sts.

19 (a) (Date rec'd by registrar) (b) Registrar's No.

FEB 10 1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2-10 1947, at 8:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-8 1947, to 2-10 1947, and that I last saw HER alive on 2-10 1947.

| Immediate cause of death CARDIAC FAILURE | Duration |
|---|---|
| Due to CONGETIVE HEART FAILURE. | |
| Due to POSSIBLE CORONARY THROMBOSIS | |
| Other Conditions HYPOTHYROIDISM. | |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Janeva Roberts M. D.
Mercy Hospital Date signed 2-10-47

94a

G48148

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 92a

Registered No. G48148

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5721 Narcissus Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Rosalie Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Black. | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-13-13

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 33 | 1 | 27 | hr. min. |

9. Birthplace n.b. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Greer
13. Birthplace n.b.

MOTHER
14. Maiden Name Katie Miller
15. Birthplace n.b.

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13 1947 (month) (day) (year)
(c) Cemetery or crematory ST. JAMES
Location NEWTON, N.C. R#1

18 (a) Funeral director Willis Reynolds Funeral Home
(b) Address NEWTON, N.C.

19 FEB 10 1947 Huntington Williams, M.D. (Date filed by Registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9 1947, at 4.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 8 1947, to Feb-9 1947 and that I last saw h[illegible] alive on Feb-9 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary Occlusion | Unknown |
| Due to Arteriosclerosis | " |
| Due to | |
| Other Conditions Aortic insufficiency | " |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Thomas Card M. D.
Address Johns Hopkins Hosp Date signed 2/10/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48149 — BALTIMORE CITY HEALTH DEPARTMENT — G48149

# CERTIFICATE OF DEATH 1467

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Fayette & Pulaski Sts.
(c) Hospital or institution: Bon Secours Hosp. 19-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 220 S. Vincent St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs. Maude Rigby

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: George Rigby
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1882

8. AGE: Years 64 | Months 11 | Days 23 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Jesse Levering
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Maryland

16 (a) Informant Mrs. Ruth Sigwart
(b) Address 332 S. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-11-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Geo. L. Lefevre
(b) Address 2491 Frederick Ave.

FEB 10 1947
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 1947 at 4:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-28 1946 to 2-8 1947 and that I last saw h[illegible] alive on 2-7 1947.

Immediate cause of death: Cardio-respiratory failure — Duration
Due to: Pneumonia
Due to: Generalized carcinomatosis from Ca of rectum
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation Sept-12, 1946
Major findings of operation: Carcinoma of rectum
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Farber M.D.
Address Bon Secours Hosp. Date signed 2-8-47

X

G48150
504929

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G48150
Registered No. 106 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Allegheny
(c) City or town Frostburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. 126 E. Lee St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Merrill Tyler

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | W. White | |

6 (b) Name of husband or wife 4-10-43
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-10-43

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 3 | 10 | - | hr. min. |

9. Birthplace New York
(Town, county and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Merrill Tyler
13. Birthplace Pa
MOTHER 14. Maiden Name Annie Leybarger
15. Birthplace

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (b) Date thereof FEB-10-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory CLEARFIELD
Location PENNA.

18 (a) Funeral director John D. Mitchell & Son
(b) Address 2700 Eutaw Pl.

19 (a) (b) Joe Williams, M.D. Registrar

FEB 10 1947

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb 10, 1947, at 8:35 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 1946 to Feb. 10, 1947. and that I last saw he/she alive on Feb. 10, 1947.

| Immediate cause of death | Duration |
|---|---|
| (a) Infection of Chest + Mediastinum | 14 da |
| Due to Post-operative | |
| Due to | owv |
| Other Conditions Pectus excavatum | |

(Include pregnancy within 3 months of death)
Date of operation 1/21/47
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry S. Batmon
Address Johns Hopkins Hosp. Date signed M. 2 D. 3 Y. 47

X

G18151

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1190a

G18151
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 dys
(e) Length of stay in Baltimore (yrs., mos., or days) 3 dys

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balt
(c) City or town Owings Mill
(If outside city or town limits, write RURAL and give town)
(d) Street No. North Branch Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Harry Clinton Baugher III

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1946

8. AGE: Years | Months: 1 | Days: 21 | If less than one day: hr. min.

9. Birthplace Frederick, Frederick Co., Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Harry Clinton Baugher Jr.
13. Birthplace Daysville, Md.

MOTHER
14. Maiden Name Gladys Shover
15. Birthplace New Boston, Ohio.

16 (a) Informant Mother
(b) Address Owings Mills, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 13, 46 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick, Md.

18 (a) Funeral director C. E. Cline & Son
(b) Address Frederick, Md.

(a) (Date rec'd by Registrar) 1941 (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10/47 19... at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/7/ 1947 to 2/10 1947 and that I last saw him alive on 2/10/ 1947.

Immediate cause of death Dehydration
Diarrhea - Vomiting
Malnutrition — Duration

Due to

Due to

Other Conditions Possible Death
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Y. Massenburg M. D.
Address University Hosp. Date signed 2/10/47

VS 150

G18152

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G18152

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 41 days
(e) Length of stay in Baltimore (yrs., mos., or days): 41 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: NC (b) County:
(c) City or town: Scotland Neck
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 319 S. Roanoke St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

**3 (a) FULL NAME:** Edwards, Walter Wayne

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married Edwards |

6 (b) Name of husband or wife: Frankie Savage
6 (c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): Nov. 21, 1897

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 49 | 2 | 20 | hr. min. |

9. Birthplace: NC (Town, county, and state)
10. Usual Occupation: Boatswain
11. Industry or business: Seafarer

FATHER
12. Name: Walter A. Edwards
13. Birthplace: NC

MOTHER
14. Maiden Name: Mary Lou Worden
15. Birthplace: Ill.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-11-47 (month) (day) (year)
(c) Cemetery or crematory: Goldsboro N.C
Location: Goldsboro N. C.

18 (a) Funeral director: Acker Funeral Home Inc
(b) Address: 403 E. 25th St.

FEB 10 1947 Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Feb. 10 1947, at 1:44 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 31 1946, to Feb. 10 1947, and that I last saw him alive on Feb. 10 1947.

| Immediate cause of death | Duration |
|---|---|
| Pneumonia, bronchial | |
| Due to Bronchiectasis, right lower lobe | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: Same

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Frank B Lovell M. D.
Address: U.S. Marine Hospital Date signed: 2-10-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48153

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G48153 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 804 William St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 804 William St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** George A. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Annie

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) March 26, 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 10 | 14 | hr. min. |

9. Birthplace England (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Annie Smith
(b) Address 804 William St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Washington, D.C.

18 (a) Funeral director John F Kenny Inc
(b) Address 714 Light St.

19 (a) (Date rec'd by registrar) (b)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/9/47 19 at 6:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 19 47 to 2-9- 19 47, and that I last saw h[illegible] alive on 2-9- 19 47

| Immediate cause of death | Duration |
|---|---|
| Cardiac Heart Failure | |
| Due to Myocarditis | 1 |
| Due to Arteriosclerosis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2 W Lexington St Date signed

VS 130 FEB 11 1947 Registered

X 2/10/47

G48151

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G48151 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1605 N. Regester St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 N. Regester St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elonora E. Thillmann

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-1171A

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | M |

6 (b) Name of husband or wife Lawrence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 1 | 13 | hr. min. |

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Carlton Burgan
13. Birthplace Baltimore

MOTHER
14. Maiden Name Caroline Meyers
15. Birthplace Baltimore

16 (a) Informant Lawrence Thillmann
(b) Address 1605 N. Regester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location E. Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) (Date rec'd) (b) Huntingtown, Williamsville, Md. Registrar

FEB 11 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/8/ 1947, at 4:38 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1947 to Feb 8 1947 and that I last saw h[illegible] alive on Feb 8 1947

Immediate cause of death Cerebral apoplexy — Duration

Due to Arteriosclerosis

Due to

Other Conditions Arteriosclerotic CV disease
(Include pregnancy within 3 months of death.)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Conrad L. Richter

Address 1706 N. Washington St. Date signed 2/10/47 M. D.

Richter X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48155

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 170c

Registered No. G48155

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 917 E 30th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Michael Kraft

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Margaret V. Schissler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch 2 - 1909

8. AGE: Years 37 | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business

FATHER 12. Name Michael

13. Birthplace Balto md

MOTHER 14. Maiden Name Ella Ganz

15. Birthplace Balto

16 (a) Informant Margaret V. Kraft

(b) Address 917 E 30th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/42 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location North ave & Rose St

18 (a) Funeral director Clarence F. Hoffman

(b) Address 1639 Broadway

19 (a) Date Rec'd by Registrar 2-11-1942 (b) Huntington Woodlawn, Md.

VS 191

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 9 1942 at 2:10 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fractures base of skull and first and second cervical vertebrae; Intracranial hemorrhage; Laceration of the brain.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 12/4

(a) Date of injury 2-9-42 at 2 a M.

(b) Where did injury occur? Greenmount Ave. 35' south of 30th St.

(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no

(d) Means of injury Pedestrian struck by auto

23. Signature Thomas J. Mascari M.D. Medical Examiner.

Date signed 2-10-42

G48156

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 108

Registered No. G48156

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAKING UNSERVED FOR [illegible] READING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Grad Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 Gorsuch Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS W. WOOLFORD

3 (b) If veteran, name war W

3 (c) Social Security Account No. NONE

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Woolford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 28th 1889

8. AGE: Years 57 | Months 9 | Days 11 | If less than one day hr. min.

9. Birthplace Woolford Co Md.
(Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business Bethlehem Steel Co

FATHER 12. Name Steven W. Woolford

13. Birthplace

MOTHER 14. Maiden Name Margaret L. Lowe

15. Birthplace Md.

16 (a) Informant Mary Woolford

(b) Address 1714 Gorsuch Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/47 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St Paul St.

19 (a) [illegible] (b) Huntington Williams, Mt

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/9/1947, at 7:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/8 1947 to 2/9 1947 and that I last saw him alive on 2/9 1947.

Immediate cause of death ACUTE LEFT VENTRICULAR FAILURE — Duration

Due to PNEUMONIA, RT - LEFT LOWER LOBES

Due to

Other Conditions ACUTE FATTY DEGENERATION OF LIVER
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy PNEUMONIA, FATTY LIVER

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Gabrielsky M. D.
Address 3106 Rosedale Rd Date signed 2/10/47

VS 150

G18157 M - 75681

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G18157

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-9-8
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Joseph Sharar

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| NV | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 5 | 7 | hr. min. |

9. Birthplace Hagerstown, Md.
(Town, county, and state)
10. Usual Occupation Chair Caner
11. Industry or busines Md. Workshop for Blind

FATHER
12. Name Joseph H. Sharar
13. Birthplace Pa.

MOTHER
14. Maiden Name Rose Witmer
15. Birthplace Md.

16 (a) Informant B. C. Hospital Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 2/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 317 St. Paul St.

FEB 11 1947 (b) Huntington Williams Registrar
(Date rec'd by registrar)

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb. 9 1947, at 6.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1942 to Feb. 9 1947, and that I last saw h. alive on Feb. 9 1947.

| Immediate cause of death | Duration |
|---|---|
| ? Coronary occlusion | |
| Due to Hypertensive C-V Disease. | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert R. Farber M. D.
Address Balto. City Hosp. Date signed 2-9-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48458 — 168 — Registered No. G48458

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 704 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Clifton Hopkins

3 (b) If veteran, name war: World War
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife: Irene Mack Hopkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 23rd 1904

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 42 | 11 | 16 | hr. min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Pipe Fitter
11. Industry or business Sinco Oil Co.

FATHER
12. Name Hopkins
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Irene M. Hopkins
(b) Address 704 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/47 (month) (day) (year)
(c) Cemetery or crematory U. S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) FEB 11 1947 (Date received by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 1947, at 2 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Subarachnoid Hemorrhage
Due to or as a consequence of Hypertrophy Dilatation of Heart
Acute Pulmonary Edema.

Other Conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-9-47 at 1:30 A.M.
(b) Where did injury occur? Wilkens Ave & Preston
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Blunt force

23. Signature Howard J. Weaver M.D. Medical Examiner.
Date signed 2-10-47

VS 181

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18159
504454

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G18159

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Spring Grove
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Edward Earl Disney

3 (b) If veteran, name war: WW
3 (c) Social Security Account No. NONE

| 4. Sex | 5. Color or race | 6 (a) ~~Single, married, widowed, or~~ divorced. |
|---|---|---|
| Male | White | Divorced |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-13-11

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 35 | 10 11 | 27 | hr. min. |

9. Birthplace Va
(Town, county, and state)
10. Usual Occupation Seaman
11. Industry or business

FATHER
12. Name Herbert S. Disney
13. Birthplace A.A. Co. Md

MOTHER
14. Maiden Name Florence Atkinson
15. Birthplace Balto Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 2/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.
18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.
19 (a) (b)
(Date rec'd by registrar) Registrar

FEB
Huntington

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1947 at 5.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 6 1947 to Feb. 10 1947 and that I last saw him alive on Feb. 10 1947.

| Immediate cause of death | Duration |
|---|---|
| Post-operative Bronchopneumonia | 12. |
| Due to | |
| Due to | |
| Other Conditions Schizophrenia | |

(Include pregnancy within 3 months of death)
Date of operation Feb 2 Feb 1947
Major findings of operation: Cortical atrophy; Cerebral edema
of autopsy: Refused

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur B Long M. D.
Address Johns Hopkins Hosp. Date signed 2/10/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43160

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 B

Registered No. G43160

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3101 Kenyon Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3101 Kenyon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Henry T. Beck

3 (b) If veteran, name war --

3 (c) Social Security Account No. 215-03-8483

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Bessie Beck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 7 | 16 | 17 hr. min. |

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Millwirght Beth. ST. Co.
11. Industry or business

FATHER
12. Name Louis Beck
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Madeleine Hammel
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Bessie Beck
(b) Address 3101 Kenyon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 11/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto. Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 10 FEB 11 1947

Assistant Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 8 1947, at 7 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to Feb 8 1947 and that I last saw h[illegible] alive on Feb 7 1947.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of stomach | 6 mos |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation Nov 11 1946

Major findings of operation: Carcinoma of stomach with peritoneal implantations

of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. T. Beck M.D.
Address 610 York Rd Date signed Feb 10 1947

X

G48161

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

Registered No. G48161

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1254 Washington Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give name)
(d) Street No. 1254 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William H. Schulze

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Estelle Green

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18, 1859

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 88 | | 22 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Watchmaker

11. Industry or business Retired

FATHER
12. Name Ludwig C. Schulze
13. Birthplace Germany

MOTHER
14. Maiden Name Muellenbeen
15. Birthplace Germany

16 (a) Informant Edna Gordon
(b) Address 1254 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 12/47 (month) (day) (year)

(c) Cemetery or crematory St Pauls Cemetery
Location Dulaneyville, Md.

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-03 Hollins St

19 (a) (Date received by registrar) (b) Registrar

FEB 11 1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 9 1947 at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1946 to Feb 9 1947, and that I last saw h.i.m. alive on Feb 3 1947

Immediate cause of death Chronic myocarditis with myocardial degeneration — Duration 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P. Ulrich Jr
Address 1224 Wash. Blvd Date signed 2/10/47

X

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G43162

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. G43162

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3332 Gwynn Falls Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3332 Gwynn Falls Parkway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Edith P. Leppold

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| female | white | widow |

6 (b) Name of ~~husband~~ or wife Late Louis A
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70. | 1 | 3. | hr. min. |

9. Birthplace Cumberland, Md. (Town, county, and state)
10. Usual Occupation Home work
11. Industry or business at home

FATHER
12. Name Henry Brook
13. Birthplace Cumberland, Md.

MOTHER
14. Maiden Name Elizabeth Sanders
15. Birthplace Cumberland, Md.

16 (a) Informant Mrs. Lyman A. Leppold
(b) Address 3332 Gwynn Falls Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Baltimore, Md.

18 (a) Funeral director John J. Cowan & Son
(b) Address 201-03 Williams St.

19 (a) (Date rec'd by registrar) (b) Interring for Williams, Registrar

FEB 11 1947

VS 100

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 9th 1947, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6 1945, to 2/9 1947, and that I last saw h[illegible] alive on 2/9 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral hemorrhage | 4 hrs. |
| Due to Arteriosclerosis | 5 |
| Due to Hypertension | 7 |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at P M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature Robert A. Peete M. D.
Address 340 E Monument Date signed 2/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48163

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

93D

Registered No. G48163

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3111 Juneau Place
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 d
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3111 Juneau Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FERDINAND J. ADAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Anna Adams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20-1873

8. AGE: Years 73 | Months 9 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Charles Adams
13. Birthplace Germany

MOTHER 14. Maiden Name Veronica Hess
15. Birthplace Germany

16 (a) Informant Anna Adams
(b) Address 3111 Juneau Pl.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director John A. Logan
(b) Address 4201 Hemmart Ave

19 (a) FEB 11 1947 (Registrar) Waiting for Will Baltimore, Md.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9/47 19 , at 6:30 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH (1) Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Devine M.D.
Medical Examiner.
Date signed 2/9/47

VS 151

X

G18164 BALTIMORE CITY HEALTH DEPARTMENT G18164

# CERTIFICATE OF DEATH 1113 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital DOA

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give name of county)
(d) Street No. 705 W Franklin St (If rural give location)
(e) Citizen of foreign country? yes (Yes or No) If yes, name country Virgin Islands

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

3 (a) FULL NAME Charles Bundorph

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1896

8. AGE: Years 50 | Months 9 | Days 3 | If less than one day ____hr. ____min.

9. Birthplace St. croix - Virgin Islands (Town, county and state)

10. Usual Occupation cook.

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Hester Mitchell
(b) Address 705 - W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/47 (month) (day) (year)
(c) Cemetery or crematory National Cemet.
Location Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19. (a) Date received by Registrar 2-11-1947 (b) Registrar Williams, M.D.

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 8th 1947, at 9:35 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Reddick M.D. Medical Examiner
Date signed Feb 9-1947

X

G48165

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

937

G48165 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens
(c) Hospital or institution:
St Agnes Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. St Pauls Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sister M. Cornelius Kowtch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 63 Months Days If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business R.C.

FATHER 12. Name Not Given

13. Birthplace "

MOTHER 14. Maiden Name Not Given

15. Birthplace "

16 (a) Informant Sr Mary Rosken

(b) Address 901 Chesapeake St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 14 47 (month) (day) (year)

(c) Cemetery or crematory Mount Olivet

Location Glyndon

18 (a) Funeral director Geo M. Fritz & Son

(b) Address 811 N Wolfe St

19 (a) FEB 11 1947 (Date received by Registrar) Registrar for Williams Registrar, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10 1947, at 6:38 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/14 1947, to 2/10 1947, and that I last saw her alive on 2/10 1947.

Immediate cause of death Cardiac failure - Rupture Myocardium

Coronary Occlusion

Due to H C D

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr Mundy

Address Hooper Date signed 2/10/47 M. D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48166

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G48166 Registered No.

# CERTIFICATE OF DEATH 46F

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Dukeland & Poynter Ave
(c) Hospital or institution: W & T Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Pa. (b) County
(c) City or town Haverford (If outside city or town limits, write RURAL and give town)
(d) Street No. 9 Dreycott Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Minnie M. Ritte

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Howard F. Ritte

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1868

8. AGE: Years 78 | Months 6 | Days 22 | If less than one day 23 hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation -

11. Industry or business

FATHER 12. Name Bankard

FATHER 13. Birthplace England

MOTHER 14. Maiden Name Sarah Mitten

MOTHER 15. Birthplace Westminster, Md.

16 (a) Informant Mr. Gordon A. Ritte

(b) Address 8 Dreycott Lane, Haverford, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/47 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.

Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Baltimore, Md. Huntingtown Williamsport, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

28. DATE OF DEATH 2-9 1947, at 4:45 P M

29. I certify that death occurred on the date above stated; that I attended deceased from 2-7 1947 to 2-9 1947, and that I last saw her alive on 2-9 1947

Immediate cause of death Carcinomatosis Peritonaei Secondary to Primary Source Unknown — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Same as Above

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signed Benjamin Budnitzky M. D.

Address West Baltimore General Hosp Date signed 2/9/47

X

VS 150

G48167

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 47D

Registered No. G48167

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 305 E. Lorraine Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 305 E. Lorraine Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** RALSTON M. SEARS, Sr.

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Myrtle A. (nee Stallings)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 7 | 9 | hr. min. |

9. Birthplace A. A. Co., Md.
(Town, county, and state)
10. Usual Occupation Guard
11. Industry or business Glenn L. Martin

FATHER
12. Name Bowieguard Sears
13. Birthplace A. A. Co., Md.

MOTHER
14. Maiden Name Lillian Trout
15. Birthplace A. A. Co., Md.

16 (a) Informant Mrs. Myrtle A. Sears
(b) Address 305 E. Lorraine Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Park
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Registrar

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9, 1947, at 8:00PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 15, 1946, to Feb. 9, 1947, and that I last saw him alive on Feb. 9, 1947.

Immediate cause of death: Carcinoma of Lungs — Duration: 1 year.
Due to Unknown.
Due to ✓
Other Conditions None.
(Include pregnancy within 3 months of death)
Date of operation None.
Major findings of operation: None.
+ roentgen Lungs 4.15.46 + Jan. 29, 47.
of autopsy: None

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? ✓ (Specify type of place)
(e) Means of injury

23. Signature Francis M. Ogden, M. D.
Address 2701 N. Calvert St. Date signed Feb. 10, '47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48168 (467) Registered No. G48168

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3510 Cedardale Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3510 Cedardale Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: MARTHA G. WALKER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1887

8. AGE: Years 60 | Months 0 | Days 25 26 | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name S. Hamilton Walker
13. Birthplace Balto.

MOTHER
14. Maiden Name Lucretia Uthman
15. Birthplace Balto.

16 (a) Informant Miss Georgie O. Walker
(b) Address 3510 Cedardale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 11 1947 (Date rec'd by Local Reg.) (b) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10, 1947 at 12:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 8 1946 to Feb 10 1947 and that I last saw h ed alive on Feb 10 1947.

Immediate cause of death: Edema cerebrum & Peritonitis & metastatic Ca

Due to: Ruptured Fungus Ca Colon and

Due to: Stroke

Other Conditions: Myocardial & renal. (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chester A Warner M. D.
Address 3312 Edgerton Road Date signed 2/10/47

V S 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48169 BALTIMORE CITY HEALTH DEPARTMENT ✓ G48169
CERTIFICATE OF DEATH 179a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4010 Round Top Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Ulrich .

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25, 1926

8. AGE: Years 20 | Months 9 | Days 15 | If less than one day hr. min.

9. Birthplace Dallas, Texas (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name -
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary E. Rommel
15. Birthplace St. Georges, Del.

16 (a) Informant Mr. Francis V. Ulrich
(b) Address 4010 Round Top Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 11 1947 (Date rec'd by Local Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10 1947 at 5:05 A.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arsenic Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 9/2
(a) Date of injury 2/10/47 at Bet. 2 & 3 A.M.
(b) Where did injury occur? 4010 Round Top Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Ingestion of Poison by mouth

23. Signature George D. Merrill M.D. Medical Examiner.
Date signed 2/10/47

VS 181

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48170

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93

Registered No. G48170

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 516 Stamford Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 Stamford Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: DR. J. NEWTON BAGWELL

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ethel Lee Bagwell
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): July 8, 1877
8. AGE: Years 69 | Months 7 | Days 1 | If less than one day hr. min.
9. Birthplace: Onancock, Va. (Town, county, and state)
10. Usual Occupation: D. D. S.
11. Industry or business: Self

FATHER
12. Name: Isaiah W. Bagwell
13. Birthplace: Va.

MOTHER
14. Maiden Name: Sarah Edwards
15. Birthplace: Va.

16 (a) Informant: Mrs. Ethel L. Bagwell
(b) Address: 516 Stamford Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/12/47 (month) (day) (year)
(c) Cemetery or crematory
Location: Onancock, Va.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Baltimore, Md.

19 (a) (b)
(Date received by Registrar)

FEB 11 1947

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9, 1947, at 5.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1946 to Feb 9 1947
and that I last saw h[illegible] alive on 2/9/47

Immediate cause of death: Coronary Occlusion
+ Duodenal Ulcer Perf.
Duration 3 hrs.
Due to Chronic Myocarditis
Duration yrs.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Emory C. Hurst
Address 19 W Church St Date signed 2/10/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C18171

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 163 H

Registered No. C18171

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 807 Jeffrey Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 H
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town (Brooklyn)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 807 Jeffrey Street
(If rural, give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

**3 (a) FULL NAME** LEROY ESTEP, JR.

3 (b) If veteran, name war

3 (c) Social Security Account No. 412-28-3806

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mildred Mary Estep

6 (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) Dec 30 - 1922

8. AGE: Years 24 | Months 1 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace Johnson City Tenn
(Town, county, and state)

10. Usual Occupation Hot Mill Operator

11. Industry or business Eastern Stainless Steel

FATHER
12. Name LeeRoy Estep Sr
13. Birthplace Tenn

MOTHER
14. Maiden Name Lula Howell
15. Birthplace Tenn

16 (a) Informant Mrs Mildred Mary Estep
(b) Address 807 Jeffrey St - 25 -

17 (a) Burial (b) Date thereof 2/12/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore Hill Cem.
Location Gr. Potatoe Hopkinsville

18 (a) Funeral director Mathews & Schilling
(b) Address 3911 Hanover St - 25

19 FEB 11 1947 (b) Huntington Williams Md
(Date rec'd by registrar)

VS 181

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/9/47 19 ____, at 1:30 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Carbon Monoxide Poisoning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2/9/47 at 12:30 M.
(b) Where did injury occur? 807 Jeffrey Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury 4 Burners on Kitchen range 2 Gas Burners

23. Signature John R Davis, M.D.
Medical Examiner.
Date signed 2/9/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48172

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G48172

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 934 E Biddle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 934 E. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Marie Anna Truelove

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife John F. Truelove

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1894

8. AGE: Years 52 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John Shanahan
13. Birthplace Md

MOTHER 14. Maiden Name Eva Miller
15. Birthplace Pa

16 (a) Informant Mrs. Truelove
(b) Address 934 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 13, 1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Peter Wiedefeld
(b) Address 906 East Biddle St

19 (a) FEB 11 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

Dr. Tillenfeld

## MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Feb 1947, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5 Feb 1947 to 9 Feb 1947, and that I last saw h[illegible] alive on 8 Feb 1947.

Immediate cause of death Coronary thrombosis — Duration 1 day

Due to Hypertension & arteriosclerosis

Due to

Other Conditions.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sigmund Silberfeld M. D.

Address 719 E. Preston Date signed 11 Feb 47

VS 190

X

G18173

# HEALTH DEPARTMENT—CITY OF BALTIMORE

G18173

## CERTIFICATE OF DEATH

93D

1. PLACE OF DEATH

Registered No.

CITY OF BALTIMORE: (No. 2214 Druid Hill Ave St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Shepard Bee

If U. S. Veteran specify WAR

(a) Residence: No. 2214 Druid Hill Ave St., 14 Ward.

(Usual place of abode) (If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. Color or Race | 5. Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | Colored | Widower |

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Alice

6. DATE OF BIRTH (month, day, year) Oct. 4 1874

| 7. AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 72 | 4 | 3 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Longshoreman

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Lottsburg, Va

FATHER

13. NAME Walter Bee

14. BIRTHPLACE (city or town) (State or country) Lottsburg, Va

MOTHER

15. MAIDEN NAME Eliza Johnson

16. BIRTHPLACE (city or town) (State or country) Lottsburg, Va

17. INFORMANT Sue Clay

(Address) 2214 Druid Hill Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Mt. Auburn Date Feb 11, 1947

19. UNDERTAKER Mrs. George H. Stallings

(Address) 63 Druid Hill Ave

20. FILED ..... 19.....

Huntington Williams, Registrar.

FEB 11 1947

### MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Feb. 7, 1947

22. I HEREBY CERTIFY, That I attended deceased from November 10, 1947 to Feb. 7, 1947

I last saw h.. alive on Feb 7, 1947. Death is said to have occurred on the date stated above, at 7:00 A.M.

The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Myocardial Degeneration | |
| | |
| | |
| Other contributory causes of importance: | |
| | |

Was an operation performed? NO Date of —

For what disease or injury? —

Name of operation —

What test confirmed diagnosis? Was there an autopsy? NO

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? NO If so, specify

(Signed) H. Franklin Culbert M. D.

(Address) 1543 Penna. Ave.

X

—WRITE PLAINLY, WITH UNFADING INK. PENCIL NOT ALLOWED. All items should be stated EXACTLY. PHYSICIAN should furnish information, should be carefully supplied. AGE should be that it may be properly classified. Exact statement of state CAUSE OF DEATH in plain terms, so that OCCUPATION is very important. See instructions on back of certificate.

G48171

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G48174 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 25-
(c) Hospital or institution: South Baltimore Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 720 Patapsco Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Albert Henninger

3 (b) If veteran, name war

3 (c) Social Security Account No. 159-03-0042

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Katherine Henninger
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 1902

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 45 | | | hr. min. |

9. Birthplace Pa
(Town, county, and state)
10. Usual Occupation Lumber Checker
11. Industry or business Wagenhamer Co

FATHER
12. Name Edward Henninger.
13. Birthplace Pa

MOTHER
14. Maiden Name Edna Uptegrove
15. Birthplace Pa

16 (a) Informant Katherine Henninger
(b) Address 720 Pontiac Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/47 (month) (day) (year)
(c) Cemetery or crematory St. Johns Lutheran
Location Pine Grove, Pa

18 (a) Funeral director Schenaweth & Donovan
(b) Address 2615-17 Clinton St.

19 (a) Huntington, Md. Registrar
(Date rec'd by reg.) FEB 11 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/8 1947, at 6 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 2/10/47

X

G18175

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G18175

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1004 Fawn Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 Fawn Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** VINCENT MARINO OR (~~MARINO~~) Merano

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-5869

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of ~~husband~~ or wife Fannie Marano (Merano)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16 1899

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 47 | 4 | 24 23 | hr. min. |

9. Birthplace Regio Calabria Italy
(Town, county, and state)
10. Usual Occupation Inspector on bottle
11. Industry or business Carr Lowrey Glass Co.

FATHER
12. Name Giuseppe Marano
13. Birthplace Italy

MOTHER
14. Maiden Name Giovannina Marano
15. Birthplace Italy

16 (a) Informant Fannie Marano (Wife)
(b) Address 1004 Fown St?

17 (a) Burial (b) Date thereof Febrary 12/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

FEB 11 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/9/47 19 , at 2:10 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Weirs, M.D.
Medical Examiner.
Date signed 2/9/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18176

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G18176

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2904 Westfield Ave
(c) Hospital or institution: 27-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2904 Westfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mariano Lomonico

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of ~~husband~~ wife: late Carmela
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19 1873

8. AGE: Years 73 | Months 6 | Days 20 21 | If less than one day: hr. min.

9. Birthplace Rana Italy (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Luigi Lomonico
13. Birthplace Italy

MOTHER
14. Maiden Name Rachele ?
15. Birthplace Italy

16 (a) Informant Charles Lomonico (Son)
(b) Address 2904 Westfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb.13 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Arnold Bellamy
(b) Address 52 N. Morley St.

19 (c) FEB 11 1947 Kentucky for Williams, Md. (Registrar)

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb. 9 1947, at 3.35 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Nov 19 1940 to Feb 9 1947. and that I last saw h. alive on Feb 9 1947.

| | Duration |
|---|---|
| Immediate cause of death: Coronary thrombosis | 12 hours |
| Antecedent cerebrovascular | 7 yrs |
| Due to disease | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23. Signature** [illegible] M.D.
Address 6217 Harford Rd Date signed July 7

E J Alessi

DC-BS-6215
G18177

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓109a

G18177
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 3514 Elm Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Catherine Arden Burton ✓

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 9, 1946
8. AGE: Years | Months: 5 | Days: 2 | If less than one day: hr. min.
9. Birthplace Maryland (town, county, and state)
10. Usual Occupation
11. Industry or business
12. Name of FATHER: Allister Arden Burton
13. Birthplace of FATHER: Md
14. Maiden Name of MOTHER: Hilda Crawford
15. Birthplace of MOTHER: Maryland
16 (a) Informant: Allister Arden Burton
(b) Address 3614 Elm Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 12 1947 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden
18 (a) Funeral director Peterson & Donegan
(b) Address 3613-17 Chestnut Ave.
19 (a) Date received by local registrar Feb 11 1947 (b) Registrar Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb. 11 1947, at 9 A. M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 22 1947, to Feb 11 1947, and that I last saw her alive on Feb 11 1947.

| | Duration |
|---|---|
| Immediate cause of death: Respiratory failure | |
| Due to: Pneumonia | |
| Due to: Pneumonia (primary?) | 3 weeks |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert A. Fuller M. D.
Address Bon Secours Hosp. Date signed 2-11-47

X

G48178

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G48178

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 S. Fagley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Guerrasio

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife xxxxxxlate Anthony Guerrasio

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 16 1877

8. AGE: Years 69 | Months 5 | Days 24 | If less than one day hr. min.

9. Birthplace Bugnara Aquila Italy
(Town, county, and state)

10. Usual Occupation housework

11. Industry or business

FATHER
12. Name Antonio Mazzocca
13. Birthplace Italy

MOTHER
14. Maiden Name Gemma Frattarola
15. Birthplace Italy

16 (a) Informant Catherine Di Giovanni (Daughter)
(b) Address 328 S. Macon St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 13 1947 (month) (day) (year)

(c) Cemetery or xxxxxxNew Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) (b)
FEB 11 1947 Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9 1947, at 10 25 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease
Due to Arteriosclerotic Cvd Disease
Other Conditions Face Abrasions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 2/9/47 at about 5 PM
(b) Where did injury occur? 205 S. Fagley St
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? no
(d) Means of injury Apparently fell down steps

23. Signature C. P. Fulmer M.D.
Medical Examiner.
Date signed 2/10/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G13179

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 97

Registered No. G13179

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4415 Frederick Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25+
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4415 Frederick Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rebecca A. Birkmeyer

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 27 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 3 | 13 | hr. min. |

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name John F. Birkmeyer
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth M. Fullbauer
15. Birthplace Germany

16 (a) Informant Louis B. Hoffman
(b) Address 4415 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 12-1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Mr. & Mrs. John W. Fenfel & Son
(b) Address 5311 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS FEB 11 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1947 at 3 25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1939 to Feb 9 1947 and that I last saw h~~e~~r alive on Feb 9 1947

| Immediate cause of death | Duration |
|---|---|
| Arterio-Sclerosis | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene Zeller, M.D.
Address 2739 Eastern Ave Date signed 2/11/47 M. D.

Birth Certificate

G-70104

G48180

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

History # 411770

N159

Registered No. G48180

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town Legore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy "B" Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 8, 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 3 | hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Herman Davis
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Barbara Bartenschlager
15. Birthplace Pennsylvania

16 (a) Informant Hospital Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12 1947 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location LeGore Md.

18 (a) Funeral director Bourke & Hartzler
(b) Address Woodsboro Md.

19 FEB 11 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 11 19 47 at 4:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 8 19 47 to Fe. 11 19 47 and that I last saw him alive on Feb. 11 19 47.

| Immediate cause of death | Duration |
|---|---|
| Atelectasis | |
| Due to Prematurity | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Russell Forden M. D.
Address Johns Hopkins Hospital Date signed 2-11-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18181

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 1170

Registered No. G18181

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto.
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 34 Walkers Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES H. G REBE

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M. | W. | married |

6 (b) Name of husband or wife Eliz a. (Jones)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20-1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 3 | 19 | hr. min. |

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Frederick Grebe
13. Birthplace Balto

MOTHER
14. Maiden Name Mary A. Ostermann
15. Birthplace Balto Md

16 (a) Informant Walter + Miss Grebe
(b) Address Middle River Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-12-47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md

18 (a) Funeral director Jno. J. Connelly
(b) Address 4 E Eutaw St

19 (a) FEB 10 1947 (b) Jno. J. Connelly (Date received by Registrar) (Signature of Registrar)

VS 150 FEB 11 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/8 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/27/47 1947 to 2/8 1947, and that I last saw h. Jm alive on 2/2 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary Occlusion, ppatic | |
| Ischemia | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jay Griffith
Address Sinai Hosp Date signed 2/10/47

X

G48182

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 83a

Registered No. G48182

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 114 S. Melrose Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-12
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city limits, write RURAL and give town)
(d) Street No. 114 S. Melrose Av (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Agnes A. Schlieffer

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, (widowed) or divorced. |
|---|---|---|
| Female | White | |

6 (b) Name of husband or wife Edward.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 22-1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 2 | 18 | min. |

9. Birthplace St. Louis Mo. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Frederick Bittlemeyer

13. Birthplace Baltimore

MOTHER 14. Maiden Name Mary M. Mahon

15. Birthplace Maryland.

16 (a) Informant Albert Bittlemeyer

(b) Address Timonium Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/47 (month) (day) (year)

(c) Cemetery or crematory Mem. Park.

Location 10th Frederick Rd.

18 (a) Funeral director John A. Wilson

(b) Address 4201 Belmont Ave

19 (a) FEB 11 1947 (b) Filed by Registrar Williams M.H.

(Date rec'd by Local Registrar)

V S 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/10/47, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 19 41 to Feb 10 1947. and that I last saw h.im alive on Feb 10 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 2 hours |
| Due to Hypertension | years |
| Due to Arteriosclerosis | years |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address 205 Bunton Street Date signed 2/11/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G48183

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1813 Poplar Grove St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 66 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 Poplar Grove St., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Jacob Wernz

3 (b) If veteran, name war ---

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widower |

6 (b) Name of husband or wife Louise P. Wernz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1863

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 84 | 1 | 9 | hr. min. |

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Not Known

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Mrs. Paul J. Belschner
(b) Address 1813 Poplar Grove St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.,

19 Filed FEB 11 1947 Huntington Williams, M.D.

-VS 150

**MEDICAL CERTIFICATION** 5.15

20. DATE OF DEATH February 10, 1947, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 5 1947 to Feb 10 1947 and that I last saw him alive on Feb 10 1947

Immediate cause of death Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions Cardio Ves Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ernst H. Kahn, M.D.
Address 1736 Poplar Grove St Date signed 2/11/47

X

G18184

BALTIMORE CITY HEALTH DEPARTMENT X

# CERTIFICATE OF DEATH 46E

G18184 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

**2. USUAL RESIDENCE OF DECEASED:** Anne Arundel
(a) State Maryland (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. Patapsco Ave. North Linthicum (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mae Hazel Scrimger

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-4222

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife William B. Scrimger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/31/02

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 44 | 3 | 10 | hr. min. |

9. Birthplace Wash. D.C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Leroy Galer
13. Birthplace Wash. D.C.

MOTHER
14. Maiden Name Grace Clark
15. Birthplace Centreville, Iowa

16 (a) Informant Miss Babette D. Scrimger
(b) Address Patapsco Ave., N. Linthicum

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-47 (month) (day) (year)
(c) Cemetery or crematory New Balto. National
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

19 FEB 11 1947 (Date rec'd by reg.) Huntington Williamsport, Md.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1947, at 2.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 31 1947, to Feb 10 1947, and that I last saw h alive on Feb 10 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Embolism | |
| Due to Coronary Thrombosis | |
| Due to Long Bone | |
| Other Conditions Interstitial Obstruction | |

(Include pregnancy within 3 months of death)
Date of operation Feb 7 1947
Major findings of operation: Cancer
of Pelvic Glands
or autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank Hutchins M.D.
Address 1213 Light St. Date signed 2/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18185 BH G53168

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G18185 / 108

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address ..... 27-
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dor
(e) Length of stay in Baltimore (yrs., mos., or days) .....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 Springfield Ave (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Thomas H. Ferguson

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced. .....
6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) 8/3/46
8. AGE: Years ..... Months 6 Days 5 If less than one day ..... hr. ..... min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business .....
FATHER 12. Name Lawrence Ferguson
13. Birthplace Md
MOTHER 14. Maiden Name Rosa ?
15. Birthplace Va
16 (a) Informant Rosa Ferguson
(b) Address 1206 Springfield ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-11-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Md.
18 (a) Funeral director Rayner Sanders
(b) Address 1413 E. Preston St
19 (a) (Signature of day registrar) Huntington Williams M.D. (Registrar)

FEB 11 1947

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/8 Th 1947 at 12 15 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH ..... Lobar pneumonia

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 2/10/47

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18186 GC# G49429 BALTIMORE CITY HEALTH DEPARTMENT 1CENROAD CERTIFICATE OF DEATH √ 33B Registered No. G18186 48486

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: D.O.A. at Sydenham Hosp. 12-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mo.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 437 W. 24th St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Icenroad, Jr.
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | S |

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 16-46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 7 | 23 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name William Icenroad
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mae Edwards
15. Birthplace Baltimore

16 (a) Informant William Icenroad
(b) Address 437 W. 24th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave.

18 (a) Funeral director John F. Miller
(b) Address 2534 Jefferson St.

FEB 11 1947 (Date received by registrar) (c) Huntington Williams, M.D. Registrar

V S 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb. 8 1947, at 7? P.M

21. I certify that death occurred on the date above stated; that I attended deceased from — 19..., to — 19..., and that I last saw h... alive on — 19...

Immediate cause of death D.O.A.: Respiratory failure
Due to Influenzal Meningitis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harvey C. McWilliams
Address Sydenham Hosp. Date signed 2/9/47 D.
Howard J. Lemmis, M.D.X

G43187

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93E

Registered No. G43187

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland Dispensary
(b) Street address Rustless Iron & Steel
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7104 Maple Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Joseph ~~Lavuda~~ Labuda

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible]

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 42 | | | hr. min. |

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Paul Labuda
13. Birthplace Slovakia

MOTHER
14. Maiden Name Mary Kuderna
15. Birthplace Slovakia

16 (a) Informant Mary Eduns
(b) Address 7104 Maple Ave

17 (a) Burial (b) Date thereof 2-12-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Frank Grach
(b) Address 900 S. Chester St

19 (a) (b)
Date Buried by Registrar FEB 11 1947 Relating to Millard, M.D.

VS 181

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 9 1947, at 12:20 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary edema; acute congestive cardiac failure; generalized arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 2-10-47

X

G48188

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 170c

Registered No. G48188

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital T-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 913 N. Bradford St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Joseph Kudrna

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Barbara Kudrna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1877

8. AGE: Years 69 | Months 7 | Days 18 | If less than one day hr. min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Frank Kudrna
13. Birthplace Bohemia

MOTHER
14. Maiden Name Not Known
15. Birthplace Bohemia

16 (a) Informant Barbara Kudrna
(b) Address 913 N. Bradford St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2-13-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Frank Brochon
(b) Address 900 N. Chester St

19 (a) FEB 11 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1947, at 11 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fractured skull
Intracranial hemorrhage
Laceration of the brain

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 7/3
(a) Date of injury 2-8-47 at 8:30 A M.
(b) Where did injury occur? Patterson Park Ave + Eager St.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Pedestrian struck by car

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 2-10-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18189 BOH G68783

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 119a

Registered No. G18189

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1900 W. Fayette St.
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto (If outside city or town, insert name of township, village, or borough)
(d) Street No. 428 S. Patterson Park Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Mickele Ann Post

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1/27/47

8. AGE: Years | Months | Days: 16. | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation infant

11. Industry or business

**FATHER**
12. Name JOSEPH POST
13. Birthplace Balto

**MOTHER**
14. Maiden Name Elizabeth Post
15. Birthplace Balto

16 (a) Informant Joseph Post - father
(b) Address 428 S. Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Glenmore Hill Rd

18 (a) Funeral director Lilly & Zeiler
(b) Address 402 S. Broadway

19 (a) (Date received by registrar) FEB 11 1947 (b) Huntington, Williamsport, Md.

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb 11 1947 at 12 45 M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1947 to Feb 11 1947, and that I last saw h[illegible] alive on Feb 11 1947

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to acidosis | |
| infection diabetes | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23.** Signature William F. Love M. D.
Address Bon Secours Hosp. Date signed 2/11/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48190

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G48190 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4013 Liberty Heights
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 1
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 Clifton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Louisa A Mosher

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife [illegible]
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 13 1875

8. AGE: Years 71 | Months 10 | Days 26 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Henry Quarrengasser
13. Birthplace Md

MOTHER 14. Maiden Name Dont Know
15. Birthplace

16 (a) Informant John F Mosher
(b) Address 1629 Clifton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-12-47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Co Md

18 (a) Funeral director Nelson L Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date received by registrar) (b) Registrar

FEB 11 1947

VS 150

Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2-9-47, 1947, at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1947 to 2/9 1947, and that I last saw h[illegible] alive on 2/8 1947

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 weeks

Due to Hypertension — Duration: ?

Due to — Duration:

Other Conditions Arterio-sclerotic Cardio-vascular disease — Duration: ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Blum M.D.
Address 1206 E. Preston St Date signed 2/11/47

83a

G48191 BCH BALTIMORE CITY HEALTH DEPARTMENT G48191

G47178 CERTIFICATE OF DEATH 157B Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2710 Byrd Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mo
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2710 Byrd Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Carolyn Brown Pollard

3 (b) If veteran, name war —

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age 8 Mo years

7. Birth date of deceased (mo., day, yr.) May 16 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 8 | 24 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER 12. Name Wm T. Pollard

13. Birthplace Va

MOTHER 14. Maiden Name Helen Hudson

15. Birthplace Va

16 (a) Informant Wm T. Pollard

(b) Address 2710 Byrle Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feby 12 - (month) (day) (year)

(c) Cemetery or crematory Clover Cem

Location Clover Va

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2105 Pilliams St

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 11 1947

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feby 11th 1947, 2 50 a M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 6-15 1946 to 1-11 1947 and that I last saw h alive on 1-10 1947.

Immediate cause of death Sepsis - Antemortem Haemorrhage — Duration Days

Due to Large mass in right groin Lumbar - paralysis of lower extremities - Rupture of Sac. — Duration Several weeks

Due to Infection — Duration Several weeks

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Jan 30 Feb 2 1947

Major findings of operation: Drainage

of autopsy:

**PHYSICIAN** Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard F Daniels M. D.

Address 6 E Eager St Date signed 2-9-47

Huntington Williams, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18192

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G18192

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1711 Darley avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 Darley avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** WILLIAM V. McCLEARY

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 213-09-1696

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Alverta McCleary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1879

8. AGE: Years 67 | Months 7 | Days 13 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name William J. McCleary
13. Birthplace Tyrone, Ireland

MOTHER
14. Maiden Name Anne R. Coleman
15. Birthplace Penna.

16 (a) Informant Mrs. Anna B. Knauff
(b) Address 1711 Darley avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof FEB-13-1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location

18 (a) Funeral director Chas. L. Evans Son Inc.
(b) Address 115 W. Mt. Royal Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 1 FEB 11 1947 Washington, D.C.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 10 1947, at 9:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/12/ 1946 to 2/10/ 1947 and that I last saw h[illegible] alive on 2/8/ 1947

| | Duration |
|---|---|
| Immediate cause of death: Myocardial insufficiency | 2 days |
| Due to: Chronic myocarditis. | 3 mos |
| Due to: | |
| Other Conditions: Emphysema | 3 mos - |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Howard Barden
Address 1517 E Northern Date signed 2/10/47 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48193

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1861

G48193 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 11 [illegible]
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 930 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Leah Knox

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | Widower |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 86 | | | hr. min. |

9. Birthplace Cambridge, Md.
(Town, county and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER
12. Name Joshua Jolly
13. Birthplace Maryland

MOTHER
14. Maiden Name Hester Burris
15. Birthplace Maryland

16 (a) Informant Esther Scott
(b) Address 907 Jordan St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date received by Registrar) (b) Evington Williams, M.D. Registrar

FEB 11 1947

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9 1947, at 9:45 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
1st - 2nd - 3rd degree burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2/9/47 at about 9:45 A.M. 11/4
(b) Where did injury occur? 930 Linden Ave
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Bed caught afire while smoking

23. Signature Ralph Culbreth M.D.
Medical Examiner.

Date signed 2/10/47

X

G48191

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G48191

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos. or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 727 Harford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Henbrick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Dorothy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1901

8. AGE: Years 45 | Months 10 | Days 3 | If less than one day ..... hr. ..... min.

9. Birthplace Farmeville, Virginia
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Henbrick Sr.
13. Birthplace Farmeville, Va.

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant William Lewis
(b) Address 1213 Harlem Ave.

17 (a) Burial (b) Date thereof 2/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. [illegible]
Location Cedar Hill Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) ..... (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151 FEB 11 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8th 1947, at 405 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary tuberculosis

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature William G Kelchner M.D.
Medical Examiner.
Date signed Feb 9th 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48195

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G48195

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Obrien - Caroline Streets
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Oklahoma (b) County
(c) City or town Muskogee (If outside city or town limits, write RURAL and give town)
(d) Street No. 1320 Love Ord Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Jeanette H. Mace

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/9/43

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 3 | 3 | 2 | hr. min. |

9. Birthplace OKLAHOMA (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name James P. Mace
13. Birthplace Okla.

MOTHER
14. Maiden Name Ola Dawkins
15. Birthplace Okla.

16 (a) Informant Mrs. Jessie P. Mace
(b) Address 1326 Love Ord St. Okla.

17 (a) Funeral Burial (b) Date thereof 2-15-47 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Memorial Pk.
Location Okla.

18 (a) Funeral director Leonard J. Rogers
(b) Address 5215 Harford Rd.

19 (a) FEB 11 1947 (b) Huntington Williams, M.D. Address

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 2/11/1947, at 9:22 A.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2/6 1947 to 2/11 1947 and that I last saw her alive on 2/11/1947.

| Immediate cause of death | Duration |
|---|---|
| Cardiac Respiratory Failure | |
| Due to Interventricular defect Patent Foramen Ovale | |
| Due to Transposition of Aorta Cardiac Hypertrophy | |
| Other Conditions Pulmonary Stenosis | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Tetralogy of Fallot

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23.** Signature Robert H. Young M.D.
Address St. Josephs Hospital Date signed 2/11/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48196

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

156 B

G48196 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Dr Hamburger's Office: 1207 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 min
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 Washington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles F. Dieterich

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-4611

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mary S. Dieterich

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16 1907

8. AGE: Years 39 | Months 5 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Rigger

11. Industry or business Bethlehem Steel Co

FATHER 12. Name George Dieterich

13. Birthplace Baltimore

MOTHER 14. Maiden Name Louise Knoblock

15. Birthplace Washington D.C.

16 (a) Informant Mrs Louise Dieterich

(b) Address 40 S. Morley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 13 1947 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore

18 (a) Funeral director Frederick A. Voll

(b) Address 220 W. Lombard St.

19 (a) (Date rec'd by registrar) (b) FEB 11 1947 Registrar, M.D.

VS 191

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 9, 1947, at 2 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the cause of death were

IMMEDIATE CAUSE OF DEATH Shock

Acute pulmonary edema.

Congestion of all viscera.

Due to

Death followed injection of Prostigmine by his physician.

Other Conditions

Treatment for myasthenia gravis

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.

Date signed 2/10/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C48197

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

124B

Registered No. C48197

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 201
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1928 Wilkens Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BARR, Amos

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Nellie F. Barr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1888

8. AGE: Years 58 | Months 5 | Days | If less than one day hr. min.

9. Birthplace Lancaster Pa. (Town, county, and state)

10. Usual Occupation Watchmaker

11. Industry or business

FATHER
12. Name Amos K. Barr
13. Birthplace Lancaster Pa.

MOTHER
14. Maiden Name Elizabeth Templeton
15. Birthplace Lancaster, Pa.

16 (a) Informant Mrs Lucy Webb
(b) Address 1928 Wilkens ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Minnesota Pa
Location Millersburg Mill[illegible] Pa

18 (a) Funeral director Frederick A. Cole
(b) Address 1208 W Lombard St

19 (a) (Date rec'd by registrar) (b) Registrar Washington Hillcrest, Md

VS Form 10-2 FEB 11 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-9- 1947 at 7:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-7-1947 to 2-9-1947 and that I last saw h[illegible] alive on 2-9-1947

| | Duration |
|---|---|
| Immediate cause of death: Arteriosclerosis | |
| Due to: Hemorrhage from Esophageal Varices | |
| Due to: Portal cirrhosis | |
| Other Conditions: Arteriosclerotic CVD | |

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Univ. Hosp. Date signed 2-9-47

X

G48198

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V/31a

G48198 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RGB

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 127 S. Poppleton St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Klein, Theodore

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No. 217-14-1288

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Hazel Alison Klein
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 0 | 9 | hr. min. |

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Elevator Dispatcher
11. Industry or business

FATHER
12. Name Theodore Klein
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Katherine Ruth
15. Birthplace Balto, Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof Feb. 14 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory National
Location Baltimore

18 (a) Funeral director Fredrick A. Cole
(b) Address 208 W. Lombard St

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150 FEB 11 1947 Huntington Avenue

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 11 1947 at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 26 1947 to Feb. 11 1947, and that I last saw him alive on Feb. 11 1947.

| Immediate cause of death | Duration |
|---|---|
| Hypertensive cardiovascular disease with nephrosclerosis | 7 yrs. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
Was autopsy: None done

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 2/11/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18199

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1462

Registered No. G18199

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland 16 S. Catherine St.
(b) Street address
(c) Hospital or institution: **********
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-4 *****
(e) Length of stay in Baltimore (yrs., mos., or days) 28 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 S. Catherine Street
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

**3 (a) FULL NAME** JOSEPH RODGERS

3 (b) If veteran, name war: No.

3 (c) Social Security Account No. 213-07-3892

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Rodgers

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) March 19, 1880

8. AGE: Years 66 | Months 10 | Days 21 | If less than one day ********** min.

9. Birthplace: Lithuania (Town, county, and state)

10. Usual Occupation: Heater

11. Industry or business: Beth. Steel Corp. Md.

FATHER
12. Name: Joseph Rodgers
13. Birthplace: Lithuania

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Lithuania

16 (a) Informant: Mrs. Anna Rodgers (wife)
(b) Address: 16 South Catherine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 11/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore Maryland

18 (a) Funeral director: C. B. Wisheart & Son.
(b) Address: 1300 Eutaw Place....17

19 FEB 11 1947 (Date received by registrar) Huntington for Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 9/47 19 , at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10th 1947 to Feb 9 1947, and that I last saw him alive on Feb 9th 1947.

| | Duration |
|---|---|
| Immediate cause of death Intestinal Obstruction | about |
| Adenocarcinoma | 28 hrs |
| Due to Carcinoma | |
| of Stomach | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 18 hrs ago
Major findings of operation: Carcinoma of Stomach -
of autopsy: **********

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: **********
(a) Accident, suicide, or homicide
(b) Date of occurrence ********** at ***** M
(c) Where did injury occur? **********
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? **********
(Specify type of place) While at work?
(e) Means of injury

23. Signature
Address 410 Medical Arts Bldg. Date signed 2/10/47 M. D.

V S 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18500

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G18500

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 8-5
(c) Hospital or institution: Sinai Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Cliftview Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Elisha Cummings

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-12-1125

| 4. Sex | 5. Color or race | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~ |
|---|---|---|
| Male | White | Married |

6 (b) Name of ~~husband or~~ wife Gertrude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 8th 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 0 | 2 | hr. min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Coca Cola Co.

FATHER
12. Name George A. Cummings
13. Birthplace Md.

MOTHER
14. Maiden Name Jeannette Duncan
15. Birthplace Md.

16 (a) Informant Mrs. Mary Page
(b) Address 703 Cliftview Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/13/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

FEB 12 1947 Received by Registrar Huntington Williams, M.D.

VS 181

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-10- 1947, at 3:30 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 2/12/47

G18501

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46a

Registered No. G18501

Print age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1310 S. Highland Ave
(c) Hospital or institution: 2 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 S. Highland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** John William Rose

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Grace S.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 23rd 1871

8. AGE: Years 75 | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired Foreman
11. Industry or business Balto. Copper Works

FATHER
12. Name William Rose
13. Birthplace Germany

MOTHER
14. Maiden Name Frances (Unknown)
15. Birthplace Germany

16 (a) Informant William F. Rose
(b) Address 310 S. Highland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Extended

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

(a) FEB 12 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 10th 1947, at 7.25 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7 1947 to Feb 10 1947 and that I last saw h~~im~~ alive on Feb 10 1947

| | Duration |
|---|---|
| Immediate cause of death: Myocardial Failure, acute | 1 day |
| Due to: Carcinoma of Oesophagus | 1 yr. |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Clarence W. LeGrow M. D.
Address 601 S. Ellwood Ave Date signed 2/10

VS 150

G18503

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 45c

G18503 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1230 N Calvert
(c) Hospital or institution: 11-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1230 N Calvert St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Aldine Hinson

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Thomas S
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan 27 1893

8. AGE: Years 54 | Months 0 | Days 14 | If less than one day: hr. min.

9. Birthplace: Ala (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER — 12. Name: (Unknown) Cox
13. Birthplace: Ala

MOTHER — 14. Maiden Name: Unknown
15. Birthplace:

16 (a) Informant: Thomas S Hinson
(b) Address: 1230 N Calvert St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/12/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Slacomb
Location: Ala

18 (a) Funeral director: William Cook Inc.
(b) Address: 127 E. Paul St.

FEB 12 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Feb 11 1947 at 10 45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw her alive on 10 Feb 1947.

| | Duration |
|---|---|
| Immediate cause of death: Carcinoma Flow of mouth with cervical & pelvic | |
| Due to: many metastases | |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Arthur G Simmons M. D.
Address: 214 Med. Arts Bldg Date signed: 11 Feb 47

VS 150

G18503

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G18503 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:** 18-3

(a) Baltimore City, Maryland

(b) Street address Catonsville Ave and Wilkens

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1

(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md (b) County V

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1119 W. Lombard St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

**3 (a) FULL NAME** John O. Kurtz

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-05-2391

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 5 1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 2 | 27 | hr. min. |

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business B+O RR.

FATHER 12. Name Otto Kurtz

13. Birthplace Baltimore, Md

MOTHER 14. Maiden Name Julia Monahan

15. Birthplace Baltimore, Md

16 (a) Informant Mrs Margaret Kurtz

(b) Address 1365 Waterside Dr.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 2/14/47 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location 4300 Old Frederick Road

18 (a) Funeral director Wm. Lowman & Son

(b) Address 901-03 Baltimore Nat'l Bank Bldg.

19 FEB 12 1947 Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 2/11 1947 at 3:15 AM

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2/10 1947 to 2/11 1947, and that I last saw him alive on 2/11 1947

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure - myocardial degeneration - diabetes | |
| Due to Coma | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

**23.** Signature [illegible] M. D.

Address Stevenson Date signed 2/11/47

VS 150

Accident Room — BALTIMORE CITY HEALTH DEPARTMENT

G48501

# CERTIFICATE OF DEATH ✓61

Registered No. G48501

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland 10-1
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore — (If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 N. Eden St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Thomas Bacon

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Black | Married |

6 (b) Name of husband or wife: Jessie Bacon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1898

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 48 | 5 | 15 | hr. min. |

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Bethlehem Steel Co.

FATHER — 12. Name John Bacon; 13. Birthplace Va.
MOTHER — 14. Maiden Name Rose Davis; 15. Birthplace Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof Feb. 13. 1947 (month) (day) (year)
(c) Cemetery or crematory Location Druid Branch Va.

18 (a) Funeral director Robert L. Conway
(b) Address 1216 W. Caroline St. Huntington Station, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 12 1947

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb. 9, 1947, at 4:50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 9th 1947 to Feb 9th 1947 and that I last saw him alive on Feb. 9 1947.

| Immediate cause of death | Duration |
|---|---|
| CARDIAC FAILURE | |
| PULMONARY EDEMA | |
| Due to HYPERTENSIVE CARDIOVASCULAR DISEASE | |
| Due to | |
| Other Conditions DIABETES MELLITUS ARTERIOLONEPHROSCLEROSIS | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas D. Stephens M. D.
Address Johns Hopkins Hospital Date signed 2-10-47

For B. C. J. Zubrucki, by Howard J. Morrison, M. D. 937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43505 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G43505

# CERTIFICATE OF DEATH 1937

**1. PLACE OF DEATH:** 20-2
(a) Baltimore City, Maryland
(b) Street address 2601 Roslyn Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 N. Bentalou St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** CHARLES HENRY KRAFT

3 (b) If veteran, name war: none
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1871

8. AGE: Years 78 | Months 8 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER — 12. Name Henry Kraft
13. Birthplace Germany

MOTHER — 14. Maiden Name Margaret ?
15. Birthplace Germany

16 (a) Informant Miss Helen E. Kraft, niece
(b) Address 745 Linnard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/47 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 12 1947 Huntington Williams

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1. 1946 to Feb. 11. 1947. and that I last saw h[illegible] alive on Feb 10-47. 19

Immediate cause of death — Duration

Due to Chronic Myocarditis — several years
Due to Terminal Pneumonia — 5 da
Other Conditions age.

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation:
of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hubert G. Blake M. D.
Address Med. Arts Bldg Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48506

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 192 B

Registered No. G48506

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3313 Walbrook Ave.
(c) Hospital or institution: 15-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3313 Walbrook Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** GEORGE HENRY LITZ, JR.

3 (b) If veteran, name war: no
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Anna C. Litz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1891

8. AGE: Years 55 | Months 10 | Days 14 | If less than one day ....hr. ....min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Garage Attendant
11. Industry or business Hutzler Bros. Co.

FATHER
12. Name George H. Litz, Sr.
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary Ostendorf
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Anna C. Litz, wife
(b) Address 3313 Walbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 12 1947

Y S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-26- 1946 to Feb 10 1947 and that I last saw h[illegible] alive on Feb 9 1947.

| Immediate cause of death | Duration |
|---|---|
| Chronic Myocarditis | ? |
| Due to | |
| Due to Mitral Stenosis | ? |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. E. Nichols MD M. D.
Address Pikesville, Md. Date signed Feb 11 47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C48507

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 74a

C48507 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1720 Thames St. 2-3
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1720 Thames St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** EDWARD F. SCHLOEGEL

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 215-12-0383

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife Anna M. Schloegel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 11 | 6 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business

FATHER
12. Name Frederick Schloegel
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Katherine Market
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Rita Kwasnik
(b) Address 2801 Oakcrest Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

V. S. 150

FEB 12 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10, 1947, at 9 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to Febry 10 1947. and that I last saw b[illegible] alive on Feb 8 1947

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | ✓ |
| Due to Ch. Myocarditis | 1/1944 |
| Due to Ch Lymphatic Leukemia | 1/1944 |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Bramer M. D.
Address 801 E Lanvale St Date signed 2/4/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48508

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G48508 Registered No.

**1. PLACE OF DEATH:** 15-8

(a) Baltimore City, Maryland

(b) Street address 2101 W. Cold Spring Lane

(c) Hospital or institution: Cold Spring Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2111 Garrison Blvd. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** CHARLES E. GARMHAUSEN (Garnhausen)

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | no |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | single |

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1856

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 90 | 2 | 0 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired Butcher

11. Industry or business

FATHER

12. Name John Garmhausen

13. Birthplace Germany

MOTHER

14. Maiden Name Elizabeth Trout

15 Birthplace Germany

16 (a) Informant Mr. Thornton Dorsey

(b) Address 2111 Garrison Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/12/47 (month) (day) (year)

(c) Cemetery or crematory Western Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) FEB 12 1947 (Date rec'd by registrar) Huntington Williams Registrar

V S 150

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH Feb. 10, 1947 at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to Feb. 10 1947. and that I last saw h... alive on Feb 5 1947

| Immediate cause of death | Duration |
|---|---|
| Chronic Myocarditis | 1Yr |
| Due to Arteriosclerosis | 10Yrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [signature] M. D.

Address 2757 W Lanvale Date signed 2/11/47

X

Spec.—2-21-39—L. F. S.—500 Blks.

G48509

# HEALTH DEPARTMENT—CITY OF BALTIMORE

G48509

## CERTIFICATE OF DEATH

✓50

REGISTERED NO.

1—PLACE OF DEATH 9-3

CITY OF BALTIMORE: (No. 606 E. 33rd ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen A. Haas

(a) RESIDENCE NO. 606 East 33rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| female | white | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 9, 1880

| 7 AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 66 | 5 | 2 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John F. Haas

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Wilhelmina K. Andress

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Miss Florence A. Haas
(Address) 606 E. 33rd St.

15 Filed FEB 12 1947 19 Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1947

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1947, to Feb 11, 1947, that I last saw her alive on Feb 11, 1947, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast

(duration) 10 yrs. + mos. da.

CONTRIBUTORY (Secondary) Metastases - Glandulars, Pulmonary

(duration) yrs. 6 mos. + da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1936

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Microscopic

(Signed) , M. D.

, 19 (Address) F. V. D. Wack

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem.

DATE OF BURIAL 2/14/47 19

20 UNDERTAKER WM. J. TICKNER & SONS

ADDRESS Balto., Md.

Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

G18510

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G18510

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4307 Liberty Heights Ave
(c) Hospital or institution: 28-

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 81 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4307 Liberty Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Elizabeth Brady

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Joseph P. Brady
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 7 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 11 | 4 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ~~Patrick~~ Bratzel
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Joseph A. Brady
(b) Address 4307 Liberty Heights Ave

17 (a) Burial (b) Date thereof Feb 14 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Harry L. Ornauer
(b) Address 4204 Ridgewood Ave

(a) Date received by registrar FEB 12 1947 (b) Registrar's signature Huntington Williams M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 11th 1947, at 9h M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1940 to Feb. 11 1947, and that I last saw h.e.r. alive on Feb. 10 1947.

| Immediate cause of death | Duration |
|---|---|
| 1) Cystitis - Sclerosis Cardio-Vascular | 10 yrs. |
| Due to Disease | |
| Due to | |
| Other Conditions - Cystocele Prolapsis (Include pregnancy within 3 months of death) | 5 yrs. |

Date of operation - None
Major findings of operation:
of autopsy: - None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Earl L. Chambers
Address 4108 Liberty Hts Date signed M/D. 2/11/47

BC# G18511 F7816

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH (58)

Registered No. G18511

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 23-1
(b) Street address
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 167 Hamburg Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Milton JOHNSON ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. C

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/26/1943

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 3 | 7 | 13 | hr. min. |

9. Birthplace Baltimore City
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Milton Johnson
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Green
15. Birthplace Md

16 (a) Informant Margaret Johnson
(b) Address 143 N Hamilton St

17 (a) Burial (b) Date thereof 2-12-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Balto Co Md

18 (a) Funeral director Edward L Brown
(b) Address 108 W Montgomery St

19 (a) FEB 10 1947 (b) Registrar Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9, 1947, at 8.45 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Rheumatic heart disease
Rheumatic pneumonitis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 2-9-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G18512

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13B

G18512 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 232 Bethel Ct
(c) Hospital or institution: none 61

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 13yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto City
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 232 Bethel Ct (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Eugene Jerome Thompson

3 (b) If veteran, name war No
3 (c) Social Security Account No. none

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | Single |

6 (b) Name of husband or wife none
6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9, 1933

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 13 | 5 | 11 2 | none min. |

9. Birthplace Balto, Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER 12. Name Fleming Simpson
13. Birthplace Balto Md

MOTHER 14. Maiden Name Ethel Beatrice Thompson
15. Birthplace Balto Md.

16 (a) Informant Ethel + Beatrice Thompson
(b) Address 232 Bethel Ct

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 14, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md
18 (a) Funeral director Clary & Wilson
(b) Address 1000 Brantley ave

19 (a) (b) Registrar
Filed by registrar FEB 12 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 11 1947, at 1:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1947, to Feb 11 1947, and that I last saw h. M alive on 2-11-47

| Duration |
|---|
| |
| |
| |
| |
| over |

Immediate cause of death Malnutrition
Due to Miliary TBC
Due to Osseous TBC.
Other Conditions none
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy: none

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William L. Johnson M. D.
Address 423 Lexington Bldg Balto Md

Vs the 12 1947 Huntington Williams, MD

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48513

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 95B

G48513 Registered No.

27-13

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette Sts
(c) Hospital or institution:
Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 203 Neepsaw Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Edwin Stehl

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Louise B Stehl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-11-80

8. AGE: Years 66 67 | Months 2 | Days 29 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and State)
10. Usual Occupation Representative
11. Industry or business

MOTHER / FATHER
12. Name Justice Stahl
13. Birthplace Germany
14. Maiden Name Frederica Lauter
15. Birthplace Maryland

16 (a) Informant Louise B Stehl
(b) Address 203 Deep Dene Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-12-47 (month) (day) (year)
(c) Cemetery or crematory DRUID RIDGE
Location PIKESVILLE MD.
18 (a) Funeral director John O Mitchell & Son Inc
(b) Address 900 Eutaw Place
19 (a) Date received FEB 12 1947 (b) Name and address of registrar Huntington Williams, M.D.

VS 180

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10 1947, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19..., to 2/10 19..., and that I last saw h[illegible] alive on 2/10 1947.

| | Duration |
|---|---|
| Immediate cause of death Myocardial Failure | 1 day |
| Due to Rheumatic Heart Disease | 40 yrs |
| Due to | |
| Other Conditions Diverticulitis | 20 yrs |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Rheumatic Valvulitis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H H Southwick M. D.
Address Franklin Sq. Hosp Date signed 2/10/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48514

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 52a

G48514 Registered No.

9-1

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Stoney Run Lane
(c) Hospital or institution: McKenna Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 wks.
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 Parkwyth Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Etta C. Chandler

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| about 75 | | | hr. min. |

9. Birthplace Cecil County, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name George Chandler
13. Birthplace Del.

MOTHER
14. Maiden Name Sarah R. Caine
15. Birthplace Md.

16 (a) Informant Mr. J. L. Hofferbert
(b) Address 1234 Northview Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ River View
Location Wilmington, Del.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) [illegible] 12 1947 Huntington Williams, M.D. Registrar
(Date of this certificate)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 11 1947, at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 31 1946 to Feb 11 1947, and that I last saw h[illegible] alive on Feb 10 1947.

Immediate cause of death — Duration

Carcinomas Right Kidney — four Months

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. B. Brennan M.D.
Address 2200 Garrison Ave. Date signed 2/12/47

VS 150

G48515

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 97

Registered No. G48515

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 240 West Lanvale St.
(c) Hospital or institution: 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22.
(e) Length of stay in Baltimore (yrs., mos., or days) Lifelong

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 240 W. Lanvale
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anna Lloyd Braithwaite Thomas.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband ~~or wife~~ Richard Henry Thomas
6 (c) ~~If alive, give age~~ years

7. Birth date of deceased (mo., day, yr.) Aug 6, 1854

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 92 | 6 | 4 | hr. min. |

9. Birthplace London England
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name J. Bevan Braithwaite
13. Birthplace England

MOTHER
14. Maiden Name Martha Gillett
15. Birthplace England

16 (a) Informant Elizabeth S. Thomas
(b) Address Darlington Maryland

17 (a) Burial (b) Date thereof Feb 12 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto md

18 (a) Funeral director Henry W Jenkins Sons
(b) Address McCulloh & Orchard Sts

19 (a) (Date rec'd by registrar) (b) Registrar

VS FEB 12 1947 Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 10 1947 at 10-15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to Feb 10 1947 and that I last saw h[illegible] alive on Feb 9 1947

| Immediate cause of death | Duration |
|---|---|
| Heart failure | |
| Due to Retinit 35 Years | |
| Due to old age | |
| Other Conditions Blindness | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Henry M. Thomas Jr M. D.
Address 120 W. Calvert St Date signed Feb 10/47

X

G18516

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 131a

G18516 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2100 Eutaw Place
(c) Hospital or institution: 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2100 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Minnie Rusdorff Cotton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Larry R

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Isaac A
13. Birthplace Germany

MOTHER
14. Maiden Name Delia
15. Birthplace Germany

16 (a) Informant Larry A Cotton
(b) Address 2100 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-47 (month) (day) (year)

(c) Cemetery or crematory
Location Hebrew Friendship Cem

18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 E Balto St

19 (a) (Date rec'd by registrar) FEB 12 1947 Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2-10- 1947, at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1/46 19 to 2/10/47 19, and that I last saw h alive on 2/10/47 19.

Immediate cause of death: Pneumonia Heart Disease & Hypertension
Due to: Arteriosclerotic Heart Disease
Due to:
Other Conditions: Hypertension & Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

| Duration |
|---|
| 2 yrs. |
| 10 yrs. |
| 2 yrs. |

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury

23. Signature Harry Rusdorff M.D.
Address Same as Above Date signed 2/10/47

95B

G18517

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G18517 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1213 Light St. 25-4
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3534 Worth St. Cklyn (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Myer Radesky

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Sadie Radesky.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 11 | | min. |

9. Birthplace Russia (Town, county, and State)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Joseph Radesky
13. Birthplace Poland

MOTHER
14. Maiden Name Goldie Radesky
15. Birthplace Poland

16 (a) Informant Mrs Sadie Radesky
(b) Address 1601 Brooklyn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-47 (month) (day) (year)
(c) Cemetery or crematory Friendship Cem
Location Petrolia

18 (a) Funeral director Jack Lewis Inc
(b) Address 1464 E Balto St

19 (a) (Date rec'd by Registrar) FEB 12 1947 (b) Registrar's signature Wilhelmina M. Bo.

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb 11 1947 at 12:55 PM

**21.** I certify that death occurred on the date above stated; that I attended deceased from Feb 5 1947, to Feb 11 1947, and that I last saw h~~im~~ alive on Feb 11 1947.

| Immediate cause of death | Duration |
|---|---|
| Acute Cardiac Failure | |
| Due to Coronary Occlusion | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23.** Signature Rocco L. Saporito M. D.
Address 80 E. Balto. Bal. Md. Date signed 2-12-47

VS 150

G18518

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 125B

Registered No. G18518

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 547 Oxford St.
(c) Hospital or institution: 17-V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 547 Oxford St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lillian Johnson Massey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lucian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1903

8. AGE: Years 44 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name George Johnson

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Celeste Davis

15. Birthplace Balto. Md.

16 (a) Informant Mrs. Elizabeth Fairfax

(b) Address 930 Harlem Lane.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12, 1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Balto Co. Maryland

18 (a) Funeral director Mrs. Lee, Jr. Holland

(b) Address 1601 Druid Hill Ave.

FEB 12 1947 (Date received by local registrar) Washington Williams (Signature of local registrar)

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb. 9, 1947 at 10:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 26 1946 to Feb. 9 1947 and that I last saw h.e.r. alive on Jan. 25 1947.

Immediate cause of death: Hepatitis — Duration: 2 mo.

Due to: unknown

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas W. Harris M. D.

Address 1524 W. Franklin St. Date signed 2-9-47

VS 150

X

C43519

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 108

Registered No. C43519

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1620 N. Lexington St.
(c) Hospital or institution: 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 N. Lexington St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas H. Douglass

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1871

8. AGE: Years 75 | Months 6 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Thomas H. Douglas
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. George B. Lytton
(b) Address 1944 N. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/11/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Watkins
(b) Address 1631 Druid Hill Ave

19 (a) FEB 12 1947 (b) Date received by Registrar Huntington Williams M.D.

V S 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/9/47 19 at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11/47 19 to 2/9/47, and that I last saw him alive on 2/7/47

Immediate cause of death: Lobar Pneumonia — Duration 2 days

Due to: Myocarditis

Due to:

Other conditions: Congestive Bronchitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Manner of injury

23. Signature Edward Turnbull M. D.
Address 1631 N. Druid Hill Ave Date signed 2/11/47

G18520

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registration No. G18520

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1625 N. Mulberry St.
(c) Hospital or institution: 19-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 N. Mulberry St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

**3 (a) FULL NAME** Tiney Noel

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1886

8. AGE: Years 60 61 | Months 10 | Days 6 | If less than one day hr. min.

9. Birthplace Nottaway Co. Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Scott
13. Birthplace Nottaway Co. Va

MOTHER
14. Maiden Name Mary ??
15. Birthplace

16 (a) Informant: Mrs. Carl Lee Bassfield
(b) Address 1020 Rutland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director: Chas. Sud. H. Hulbert
(b) Address 1631 Druid Hill Ave.

FEB 12 1947 Huntington Williams, M.D.
(Date rec'd by Registrar) (Registrar)

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1947, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/2 1947 to 2/9 1947, and that I last saw h[illegible] alive on 2/7 1947.

| Immediate cause of death | Duration |
|---|---|
| Hypertensive Type Heart Disease | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Evan O Sickey, M.D.
Address 601 N Carlton St. Date signed 2/11/47

X

G48521 D.O.A accident Room

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

108

Registered No. G48521

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland 19-7
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1729 Mc Henry St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

**3 (a) FULL NAME** Edna C. Ohl

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wm H. Ohl

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr) Dec 6. 1888

8. AGE: Years 58 | Months 1 | Days 15 | If less than one day ....hr. ....min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER 12. Name George Dalker

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Carrie Myers

15. Birthplace Baltimore Md

16 (a) Informant Wm H. Ohl

(b) Address 1729 Mc Henry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 14-1947 (month) (day) (year)

(c) Cemetery or crematory Glen Haven

Location Balto Md

18 (a) Funeral director Pratt & Stricker & H. Walter

(b) Address Pratt & Stricker Sts

19 (a) FEB 12 1947 (Date rec'd by local registrar) (b) Huntington Williams, M.D. Registrar

VS 150

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH Feb. 10 1947 at 9.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1947 to Feb 10 1947 and that I last saw her alive on Feb 10 1947.

Immediate cause of death Lobar Pneumonia — Duration 1 day?

Due to.....

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy: Consolidation R.U.L.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....(Specify type of place)
(e) Means of injury.....

23. Signature Maurice B. Day M.D.

Address 1 W. 11th St. Date signed 11 Feb 47

Dr P. R. Davis, by Howard S. Mancini, M.D. X

618523

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93E

Registered No. 618523

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:** 6-1
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2818 East Baltimore St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Frank V Pipitone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret Pipitone

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 5 (illegible) 1887

8. AGE: Years 59 (illegible) | Months 6 | Days 6 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Funeral Director

11. Industry or business Own

FATHER
12. Name Vincent Pipitone
13. Birthplace Italy

MOTHER
14. Maiden Name Virginia Cerreghino
15. Birthplace (illegible) Baltimore Md

16 (a) Informant Wife
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 14-1947 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Balto - Md

18 (a) Funeral director Geo L. Berger Jr
(b) Address 1512 Hollins St

19 FEB 12 1947 (Date received by Local Reg.) Huntington Williams M.D. (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11 1947, at 3:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1947 to Feb 11 1947 and that I last saw h alive on Feb 11 1947

Immediate cause of death Cardiac Failure — Duration

Due to Congestive Heart Failure

Due to Chronic Emphysema Cardiac Asthma

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clarence E. McWilliams M. D.
Address Mercy Hospital Date signed 2-11-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

CWK-108144 — Registered No. C18523

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1042 Vine Street 2-23
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
William Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Married |

6 (b) Name of husband or wife Carrie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19-1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 9 | 20 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Benjamin
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Adams
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 12 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St.

(Date received by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 1947, at 12:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 3 1947, to Feb. 9 1947 and that I last saw him alive on Feb. 9 1947.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Hemorrhage, passive | |
| Due to Pulmonary Tuberculosis, Far Advanced | Unknown |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Refused

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilhelmine J. Hunt M. D.
Address Balt. City Hosp. Date signed 2-10-47

VS 150

G18524

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 107

Registered G18524

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1619 Division St.
(c) Hospital or institution: 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 Division St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary L. Diggs.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Robert Diggs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1861

8. AGE: Years: 85 | Months: 9 | Days: 5 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: John Henson
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Lydia Hall
15. Birthplace: Howard County, Md.

16 (a) Informant: George Henson
(b) Address: 1619 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 12, 1947 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn Cem
Location

18 (a) Funeral director: Wm. Walter Williams
(b) Address: 220 N. Eutaw St.

FEB 12 1947 (Date received by local reg.) Huntington Williams, M.D. (Signature of local registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1947 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5/47 to 2/10/47.
and that I last saw h alive on 2/8/47

Immediate cause of death: Bronchopneumonia — Duration: 5 days
Due to: Cardiac Thrombosis
Due to: Senility — 9 days

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. L. Ellis M. D.
Address 611 Mosher Date signed 2/12/47

VS 190

X

C18525

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. C18525

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1042 N. Carlton St.
(c) Hospital or institution: 18-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1042 N. Carlton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Holland

3 (b) If veteran, name war
3 (c) Social Security Account No. 217-01-8496

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Col. | Widow |

6 (b) Name of husband or wife Louise Holland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 11 1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | 5 | 29 | hr. min. |

9. Birthplace Dorchester Co. Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William Holland
13. Birthplace Cambridge Md

MOTHER
14. Maiden Name Minnie Robinson
15. Birthplace Cambridge Md.

16 (a) Informant Catherine Thomas
(b) Address 1042 N. Carlton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 14, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 922 N. Schroeder St.

FEB 12 1947 (Date received by Registrar) Katie R. Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 9 1947, at 6 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9 1947 to Feb 9 1947 and that I last saw h[illegible] alive on Feb 9 1947

Immediate cause of death: Cerebral Hemorrhage

| | Duration |
|---|---|
| Due to | 9 hrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [signature] M. D.
Address [illegible] Date signed 2/12/47

VS 150

G43526

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131C

Registered No. G43526

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1616 W. Lexington St.
(c) Hospital or institution: 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give county)
(d) Street No. 1616 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** James Chambers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Annie Chambers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1885

8. AGE: Years 62 | Months 1 | Days | If less than one day: hr. min.

9. Birthplace Annapolis Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Chambers
13. Birthplace Annapolis Md.

MOTHER
14. Maiden Name Nancy Lynch
15. Birthplace Annapolis Md.

16 (a) Informant Doris Tolson
(b) Address 1616 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 12 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.
(c) (Date received by registrar) Huntingtown Williamsport

FEB 12 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1947, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/24 1947 to 2/9 1947, and that I last saw h[illegible] alive on 2/8 1947.

Immediate cause of death: Acute Nephritis

Due to: Uremia

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benj Rhett M.D.
Address 134 [illegible] Date signed 2/9/47

G18527

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

G18527 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 647 Bartlett ave.
(c) Hospital or institution: 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 647 Bartlett Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME RUDOLPH RAMMING

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-22-5342

4. Sex: male | 5. Color or race: white | 6 (a) Single, (married) widowed, or divorced.

6 (b) Name of husband or wife Ella C. Ramming

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) 1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | | | hr. min. |

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Cap & Engraving

FATHER
12. Name Adam Ramming
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Rammig Pistel
15. Birthplace Germany

16 (a) Informant Robt. A. Ramming
(b) Address 766 Wilkens Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-47 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location City

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT AVE & 22nd ST.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 12 1947 Huntington Hillcrest, Md.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/10 1947, at 10 a.m.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ or accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. (Medical Examiner.)
Date signed 2/10/47

G18528

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

82a

Registered No. G18528

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:** St. Joseph's Hosp.
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St.
(c) Hospital or institution: Baltimore Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore Maryland
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 925 N Rose St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** John G. Dillman

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 213-10-1315

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife MAY, E.
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) JULY 9 1896

8. AGE: Years 60 | Months 7 | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace BALTO. MD.
(Town, county, and state)

10. Usual Occupation BALTO TRANSIT

11. Industry or business

FATHER
12. Name JACOB DILLMAN
13. Birthplace GERMANY

MOTHER
14. Maiden Name ROSINA ?
15. Birthplace GERMANY

16 (a) Informant MAY E. DILLMAN
(b) Address 925 N ROSE ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 14 1947 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR RD

18 (a) Funeral director MARTIN W.E. DIPPEL'S SONS
(b) Address LOMBARD & ANN STS.

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

VS 150 FEB 12 1947

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** February 11 1947 at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19- 1947 to Feb 11 1947. and that I last saw him alive on Feb. 11 1947.

| | Duration |
|---|---|
| Immediate cause of death: Cardiac - Respiratory failure. | |
| Due to: Cerebral - vascular accident due to Hypertension, essential. | |
| Other conditions: with Terminal Uremia. (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John B. Wilkinson M.D.
Address 1st Jos Hosp Date signed 2-11-47
M. D.

X

G18529

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 97

G18529 ✓ Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 229 S. Ellwood Avenue
(c) Hospital or institution: 1-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 229 S. Ellwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA MARIE (PITZ) FREDERICK

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Widow |

6 (b) Name of husband or wife George L. Frederick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7, 1855

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 91 | 8 9 | 4 | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Magnus Meisten
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Miss Emma Frederick
(b) Address 229 S. Ellwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date rec'd by reg.) FEB 12 1947 (b) Registrar Williams M.D. Acting for

**MEDICAL CERTIFICATION** AM

20. DATE OF DEATH February 11 1947, at 8.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 30 1947 to Feb 10 1947 and that I last saw h.. alive on Feb 10 1947

| Immediate cause of death | Duration |
|---|---|
| Myocardial Failure | 1 wk. |
| Due to Senile Arteriosclerosis, Generalized | 4 yrs. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clarence W. LeDoux M.D.
Address 601 S. Ellwood Ave. Date signed 2/11/47

X

G48530

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G48530

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland 25-1
(b) Street address
(c) Hospital or institution:
Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 907 Calwell Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ferdinand G (Frederick) Graefe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Louisa K

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 9 1870

8. AGE: Years 76 | Months 3 | Days 1 | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation clerk (Retired)

11. Industry or business J. J. Haines

FATHER
12. Name Henry G Graefe
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Louisa K Graefe
(b) Address 907 Calwell Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 13 '47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry A Wetzel
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Williams, Registrar

FEB 12 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH 10 Feb 1947, at 3:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 27 Jan 1947, to 10 Feb 1947, and that I last saw h.i.m. alive on 10 Feb 1947.

| | Duration |
|---|---|
| Immediate cause of death Sepsis and bronchopneumonia | |
| Due to | |
| Due to | |
| Other Conditions Arteriosclerotic heart disease | |

(Include pregnancy within 3 months of death)

Date of operation 16 Dec 46

Major findings of operation: Arteriosclerotic Gangrene of foot, etc.

of autopsy: Bronchopneumonia & Occ H.D.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature Howard H. Katz M.D.
Address Sinai Hospital Date signed 10 Feb 47

v sf

Hunter

107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G48531 BGH G67706 BALTIMORE CITY HEALTH DEPARTMENT ✓ G48531

# CERTIFICATE OF DEATH 161c

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Bon Secours 2004
(c) Hospital or institution: Fayette + Payson St
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7501 Emerson St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Patricia Carol Kuhlman [PATRICIA CAROL KUHLMAN]

3 (b) If veteran, name war

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16/47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| — | — | 27 | hr. min. |

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Walter F. Kuhlman
13. Birthplace Md.

MOTHER 14. Maiden Name Agnes Bodner
15. Birthplace Pa.

16 (a) Informant Walter F Kuhlman
(b) Address 7501 Emerson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2.13.47 (month) (day) (year)
(c) Cemetery or crematory St Michaels
Location Dundalk, Md

18 (a) Funeral director Henry H. Wolfe
(b) Address 4101 Edmondson Ave

19 (a) FEB 12 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb. 12 1947, at 3 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1947 to Feb 12 1947 and that I last saw him alive on Feb 11 1947

Immediate cause of death: Respiratory failure

Due to Erythroblastosis foetalis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |
| |

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Manner of injury
(f) Signature Robert E. Fowler
Address Bon Secours Hosp. Balto Date signed 2-12-47 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

G18532

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

G18532 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1723 Ellsworth St.
(c) Hospital or institution: S-T
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1723 Ellsworth St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Miles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Mary A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | | | hr. min. |

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Fannie
15. Birthplace N. C.

16 (a) Informant William Miles
(b) Address 1723 Ellsworth St.

17 (a) Lemondale (b) Date thereof Feb 12 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Roxboro N. C.

18 (a) Funeral director Mrs. Ella A. Gilliard
(b) Address 1629 N. Carlton St.

19 (a) FEB 12 1947 (b)
(Date rec'd by registrar) Huntington, Maryland

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 10 1947, at 9:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1947 to Feb 10 1947 and that I last saw h[illegible] alive on Feb 9 1947

Immediate cause of death: Cerebral Hemorrhage — Duration 6 days
Due to: Hypertension Cardiovascular Renal Disease
Due to:
Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. E. Gilliard
Address 1629 N. Carlton signed 2-11-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G18533

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 17-2
(b) Street address
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 524 Dolphin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adam Alston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced Seperated

6 (b) Name of husband or wife Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 60 Months Days If less than one day hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name Walley Alston
13. Birthplace N. C.

MOTHER
14. Maiden Name Alice Alston
15. Birthplace N. C.

16 (a) Informant Julia Alston
(b) Address 1019 N. Central Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 12/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County

18 (a) Funeral director Mrs. Ruth A. Elliott
(b) Address 1911 N. Gaurens St

19 (a) (Date rec'd by registrar) FEB 12 1947 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6 1947, at 2 45 P M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h.s death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature E. J. Lubowski M.D.
Medical Examiner.
Date signed 2/3/47

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X

G18534 ✓ G18534

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland 5-1
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days). DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 406 N. Caden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Evangelos HASAPOPOULOS

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov-1-1893

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 | 3 | 8 | hr. min. |

9. Birthplace Greece
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace "

MOTHER 14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof Feb 12-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greek
Location Windsor Mill Road

18 (a) Funeral director Sanders Funeral Home (Inc.)
(b) Address 440 East North Ave

19 (a) FEB 12 1947 (b) Huntington Williamsport

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 9 19 47, at 2:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary arteriosclerosis
Pulmonary edema
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrell M.D.
Medical Examiner.
Date signed 2/10/47

YS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48535

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G48535

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. General Hosp D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel Co.
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 6311 Morley Neck Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A. Moon

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-14-1455

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1914

8. AGE: Years 32 | Months 2 | Days 17/16 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business Motion Picture Co

FATHER 12. Name Harry W. Moon

13. Birthplace Md

MOTHER 14. Maiden Name Sarah Timms

15. Birthplace Md.

16 (a) Informant Family

(b) Address 6311 Morley Neck Rd

17 (a) B (Burial, cremation, or removal) (b) Date thereof 2-13-47 (month) (day) (year)

(c) Cemetery or crematory Arlington

Location Baltimore

18 (a) Funeral director H. A. Cauley

(b) Address 130 S. Fort Ave.

19 (a) Received for record FEB 12 1947 Hunting Town Williams, Md. Registrar

FEB 12 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 9, 1947, at 1:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Communited fracture of the skull, Intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-9-47 at 1:30 A.M. A.A. Co.
(b) Where did injury occur? Morley Neck Road
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature Howard J. Mercer M.D. Medical Examiner.
Date signed 2-10-47

# HEALTH DEPARTMENT—CITY OF BALTIMORE

G48536

## CERTIFICATE OF DEATH

131a G48536

9-6

Registered No.....

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1621 East 29th St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Henry Lincoln Krumm. If U.S. Veteran specify WAR .....

(a) Residence: No. 1621 E. 29th St. St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. Color or Race | 5. Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | White | Married |

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Bettie Krumm

6. DATE OF BIRTH (month, day, year) 9/21/1861

| 7. AGE Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|
| 85 | 4 | 20 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. .....

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. .....

10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) Maryland

MOTHER FATHER

13. NAME Jacob Krumm

14. BIRTHPLACE (city or town) (State or country) Germany

15. MAIDEN NAME Bettie Schwab

16. BIRTHPLACE (city or town) (State or country) Germany

17. INFORMANT Miss Bettie Krumm
(Address) 1621 East 29th. St.

18. BURIAL, CREMATION, OR REMOVAL
Place Mt. Auburn Cem. Date Feb. 13/47 19

19. UNDERTAKER F. O. Tippett & Son
(Address) 1300 Eutaw Place

20. FILED FEB 12 1947 19 ... Registrar

### MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 2/10/47, 19

22. I HEREBY CERTIFY, That I attended deceased from 2/1, 1947, to 2/10, 1947

I last saw him alive on 2/10, 1947. Death is said to have occurred on the date stated above, at 7:45P m.

The principal cause of death and related causes of importance were as follows:

| | Duration |
|---|---|
| Cerebral Hemorrhage | 1946 |
| Chronic Nephritis | 1946 |
| Uremia | 2/47 |

Other contributory causes of importance:

Was an operation performed? — Date of —

For what disease or injury? —

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signed) Walter E. Kaufman M. D.
(Address) 4331 Hayward Road

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Kartgin X

G18537

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 194a

G18537 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 3809 Greenway
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3809 Greenway (Use street and number)
(e) Citizen of foreign country? (Yes or No) ----------
If yes, name country

**3 (a) FULL NAME** Thomas F. McLaughlin

3 (b) If veteran, name war ----------

3 (c) Social Security Account No. ----------

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Lillian C Baeder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | --- | --- | --- hr. --- min. |

9. Birthplace O.J.M. Syracuse, N.Y. (Town, county, and state)

10. Usual Occupation President Eastern

11. Industry or business Stainless Steel Corp.

FATHER
12. Name Francis McLaughlin
13. Birthplace Ireland

MOTHER
14. Maiden Name Ella Flynn
15. Birthplace Pittsburgh, Pa.

16 (a) Informant Mrs. Lillian E. McLaughlin
(b) Address 3809 Greenway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. H. Mears and Son
(b) Address 805 N. Calvert St.

19 (a) FEB 12 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 191

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 10 1947, at 7.45 PM

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions Acute pulmonary edema

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mallett M.D. Medical Examiner.
Date signed 2-11-47

X

G18538

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1111a

G18538 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2241 Lake Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Mary E. Dugan

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | W |

6 (b) Name of husband or wife Thomas L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 8 | 17 | hr. min. |

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Frederick Nestor
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Hayes
15. Birthplace Ireland

16 (a) Informant Mrs. Francis Dugan
(b) Address 2241 Lake Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto

18 (a) Funeral director L. J. Ruck
(b) Address 5305 Harford Rd.

19 (a) FEB 13 1947 (b) Registered FEB 12 1947 Registrar

VS 150

Huntington Williams, Md.

FEB 12 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/12 1947 at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/11 1947 to 2/12 1947, and that I last saw h[er] alive on 2/12 1947.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Embolism | |
| Due to | |
| Due to | |
| Other Conditions Auricular fibrillation | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Nicholas M. D.
Address Univ. Hosp. Date signed 2/12/47

X

BALTIMORE CITY HEALTH DEPARTMENT 61

# CERTIFICATE OF DEATH

Registered No. G48539

G48539

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1908 Sulgrave Rd
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 2 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 Sulgrave Rd (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country -

**3 (a) FULL NAME** Mary Ruth Gooding

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. | 4. Sex |
|---|---|---|
| no | none | Female |

| 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|
| White | Widow |

6 (b) Name of husband or wife John H. Gooding
6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) July 30-1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 6 | 12 | hr. min. |

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name John Roth
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Fowler
15. Birthplace Balto. Md.

16 (a) Informant Wm. Philip N. Gooding (Son)
(b) Address 1908 Sulgrave Rd. Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 13/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn

18 (a) Funeral director Stewart & Company
(b) Address 108 W. Mt. Royal Ave.

19 (a) FEB 13 1947 (b) Registrar Huntington Williams, M.D.
~~FEB 12 1947~~
VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 11 1947. 3 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Feb 11 1947 to Feb 11 1947 and that I last saw him alive on Feb 11 1947

| Immediate cause of death | Duration |
|---|---|
| Acute Cardiac Dilatation | 2 days |
| Due to Overweight | 4 |
| Due to Diabetes | about 25 yrs |
| Other Conditions - | |

(Include pregnancy within 3 months of death)
Date of operation -
Major findings of operation -
of autopsy: -

Underlying cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide -
(b) Date of occurrence - at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury -

23. Signature P. Keyser M. D.
Address Huntington Apts. Date signed 2-12-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G18540

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G18540

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3108 Lyon View Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3108 Lyon View Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Joseph F. Bauer

3 (b) If veteran, name war W
3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Martha
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 14th 1880

8. AGE: Years 66 | Months 5 | Days 27 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Rover
11. Industry or business

FATHER 12. Name Joseph F. Bauer
13. Birthplace N.Y.

MOTHER 14. Maiden Name Anna E. Shefstad
15. Birthplace Columbus Ohio

16 (a) Informant Mrs Catherine Schmidt
(b) Address 313 E. 33rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

FEB 13 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to 2-10 1947 and that I last saw him alive on 2-10 1947

| | Duration |
|---|---|
| Immediate cause of death Coronary occlusion | 2 weeks |
| Due to Hypertension | 4 yrs |
| Due to | |
| Other Conditions Left Hemiplegia | 2 yrs |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William F. Feeney M.D.
Address 3025 Belair Rd Date signed 2-11-47

X

G18511

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

Registered No. G18511

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution: Mt Sinai Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4613 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lena M. Cohen

3 (b) If veteran, name war —

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | W |

6 (b) Name of husband or wife Abe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Mrs Ida Cohn
(b) Address 805 Lake Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-13-47 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Philadelphia Rd & Bowleys Lane

18 (a) Funeral director Sol Levy Inc
(b) Address 1439 E. Baltimore St

19 (a) FEB 13 1947 (Date rec'd by registrar)

Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 12 1947, at 2:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/9 1947 to 2/11 1947 and that I last saw him alive on 2/11 1947

| Immediate cause of death | Duration |
|---|---|
| Acute Coronary Infarction | |
| Due to Chronic Sclerosis | |
| Due to Hypertension | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. Horneker M. D.
Address 733 Argyle St Date signed 3/10/47

VS 150

G18542 BALTIMORE CITY HEALTH DEPARTMENT G18542
CERTIFICATE OF DEATH ✓ 83a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 628 Baker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 628 Baker St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Barnes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced W.

6 (b) Name of husband or wife John Barnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1891

8. AGE: Years 55 | Months 11 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name David Barnes
13. Birthplace Eastern Shore Md.

MOTHER
14. Maiden Name Annie Barnes
15. Birthplace Baltimore Md.

16 (a) Informant Eugene Barnes
(b) Address 628 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 15-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location West Pa[illegible]

18 (a) Funeral director Va Bro[illegible]
(b) Address 1437 N. Carey St

19 (a) (Date rec'd by Registrar) FEB 15 1947 Huntington [illegible]

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-12- 1947 at 2:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-10- 1947 to 2-12-1947 and that I last saw h[illegible] alive on 2-12- 1947.

Immediate cause of death Cerebral Hemorrhage — Duration 3 days

Due to Hypertension — 6 mos.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George C Page M.D.
Address 1516 N. Mount St (7) Date signed 2-13-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18513

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

G18513 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1339 N. Fulton Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-2
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1339 N. Fulton Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline Wilmer Basil

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widowed |

6 (b) Name of husband or wife William Basil deceased 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct-31-1857

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 89 | 3 | 11 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John C Fisher
13. Birthplace Baltimore

MOTHER 14. Maiden Name Wilhelmine Borgeldt
15. Birthplace Baltimore

16 (a) Informant Melba Gilster
(b) Address 7504 Windsor Mill Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 13, 1947 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director George Weber & Son
(b) Address 2503 Edmondson Ave.

19 (a) FEB 13 1947 Registered by Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH February-11 19 47 at 11 55 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from December-28 19 46 to February-11 19 47. and that I last saw h.er alive on February-10 19 47.

| Immediate cause of death | Duration |
|---|---|
| Cerebral hemorrhage | |
| Due to Hypertension | |
| Due to | |
| Other Conditions Bedsores | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walther K. Sonnenfeldt M. D.
Address 2708 Hollins Ferry Rd Date signed 2/12/47

G13544

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G13544

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 516 Otterbein St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 Otterbein St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Louise Drexel

3 (b) If veteran, name war

3 (c) Social Security Account No. None

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | white | Married |

6 (b) Name of husband or wife Rubin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 10 | 11 | hr. min. |

9. Birthplace Topeka, Kansas (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name George Howard
13. Birthplace Topeka, Kansas

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant James Drexel
(b) Address 516 Otterbien Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Avenue

18 (a) Funeral director Bernard C. Harle
(b) Address 1000 S. Paca Street

19 (a) (Date received by Local Registrar) FEB 13 1947 (b) Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 12 1947 at 2.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 7 1940 to Feb 11 1947 and that I last saw h.e.r alive on Feb 11 1947.

| Immediate cause of death | Duration |
|---|---|
| Obesity Heart Disease | 7 |
| Due to — | |
| Due to — | |
| Other Conditions Hypertension | ? |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Carl E. Rostberg M. D.
Address 1326 W Lombard St Date signed 2/12/47

X

BALTIMORE CITY HEALTH DEPARTMENT

TN. 106044 G18545 CERTIFICATE OF DEATH 132 G18545

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 17-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-months 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 540 W. Mulberry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Marks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9th. 1927

8. AGE: Years 19 | Months 10 | Days 27 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?

13. Birthplace

MOTHER 14. Maiden Name Mabel Marks

15. Birthplace ?

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave ( Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 13 1947 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location A. C., Co, Sec

18 (a) Funeral director Robt E Williams

(b) Address 1515 McElderry St

19 (a) (b) (Date rec'd by registrar) Registrar

FEB 13 1947 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 6th 1947 19..., at 12.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12th 1946, to Feb. 6th 1947, and that I last saw her alive on Feb. 6th 1947.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Hemorrhage | 2 years |
| Due to Pulmonary Tuberculosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H S Shaler M. D.

Address Baltimore City Hosp Date signed 2-6-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

47c

Registered No. C18546

C18-10519

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 16-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3- 25-
(e) Length of stay in Baltimore (yrs., mos., or days) 15 Years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 N. Calhoun Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Steady or Steady John

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22-1903

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 43 | 8 | 19 20 | hr. min. |

9. Birthplace British West Indies (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name John
13. Birthplace British West Indies

MOTHER
14. Maiden Name Nora John
15. Birthplace British West Indies

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. B. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) (b) (Registrar)

FEB 13 1947

VS 150

Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 11 19 47 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 19 46 to Feb. 11 19 47, and that I last saw h. im alive on Feb. 11 19 47.

| Immediate cause of death | Duration |
|---|---|
| Generalized Carcinomatosis | |
| Due to: Bronchogenic Ca. | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert R. Fowler M. D.
Address Balto City Hosp. Date signed 2-11-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18547

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G18547

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2601 Oswego Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 12
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2601 Oswego Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: WILLIAM A. STEVENS

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Kizziah H. Stevens
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 30, 1864

8. AGE: Years 82 | Months 9 | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: none
11. Industry or business

FATHER
12. Name: Daniel Gorden Stevens
13. Birthplace: Md.

MOTHER
14. Maiden Name: Catherine B. Ford
15. Birthplace: Md.

16 (a) Informant: Mrs. Gladys L. Holbein
(b) Address: 2601 Oswego Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/47 (month) (day) (year)
(c) Cemetery or crematory: Greenmount Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

FEB 13 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 12, 47 19..... at ..... M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1947 to Feb 12 1947 and that I last saw him alive on Feb 10 1947

| | Duration |
|---|---|
| Immediate cause of death: Coronary occlusion | 1 hr |
| Due to: Renal and Coronary Arteriosclerosis | yrs |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James E. Ashenhurst M. D.
Address Hoff Park Hotton Date signed 2-13-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48548

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 97

Registered No. G48548

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1908 Cedric Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-9
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 Cedric Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** NIVISON LONG

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 218-09-1068

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife: Maude Long (nee Stocksdale)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1864

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | 3 | 5 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Assistant Treasurer
11. Industry or business Eutaw Savings Bank

FATHER
12. Name Sidney C. Long
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary Wilson
15. Birthplace Unknown

16 (a) Informant: Mrs. Maud S. Long
(b) Address 1908 Cedric Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington [illegible], Md.

V S 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 11, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-1940 to 2-11-1947 and that I last saw h[illegible] alive on 2-11-1947.

| Immediate cause of death | Duration |
|---|---|
| Myocardial Failure | 3 days |
| Due to (Myocarditis) | |
| Due to Arteriosclerosis | — |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard H. Warner, M.D.
Address 704 Garrison Blvd. Date signed 2-13-47

X

G48549

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G48549

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4107 Norfolk Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-9
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4107 Norfolk Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** CHRISTOPHER GATALO

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Anna Gatalo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | 8 | 8 | hr. min. |

9. Birthplace Mostar, Yugoslavia (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business

FATHER
12. Name Ignatius Gatalo
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace Yugoslavia

16 (a) Informant Mrs. Ignatius Gatalo
(b) Address 4107 Norfolk Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 11, 1947, at 2:30PM

21. I certify that death occurred on the date above stated; that I attended deceased from NOV 2 1946 to FEB 11 1947 and that I last saw him alive on JAN 28 1947

| Immediate cause of death | Duration |
|---|---|
| CORONARY THROMBOSIS | 2½ MOS |
| Due to ARTERIOSCLEROTIC HEART DISEASE | 5 YRS ? |
| Due to | |
| Other Conditions VENTRICULAR TACHYCARDIA (Include pregnancy within 3 months of death) | 3 MOS |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph G. Hills M. D.
Address 18 E Eager St. Date signed 2-11-47

V 5 50 FEB 13 1947 Huntington Williams, Inc Baltimore Md X

G48550

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

43B

G48550 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: So Balto Gen Hosp 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2544 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen E. Wilhelm

3 (b) If veteran, name war N | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Robert L. Wilhelm | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/24/01

8. AGE: Years 45 | Months 2 | Days 18 | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Clarke
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Harriet Blatchley
15. Birthplace Balto., Md.

16 (a) Informant Mr. Robert L. Wilhelm
(b) Address 2544 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) FEB 13 1947 Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/12/47 1947 at 5P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/9 1947 to 2/12 1947 and that I last saw h alive on 2/12 1947

Immediate cause of death: Respiratory failure — Duration
Due to: Coronal Thrombosis
Due to:
Other Conditions: Hypostatic Pulmonia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R Carrickson
Address So Balto Gen Hosp Date signed 2/12/47 M. D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

643551

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

643551

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd St. & Guilford Ave.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 76

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2021 St. Paul St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** DELAWARE, C. ANDRE

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOWED
6 (b) Name of husband or wife: Marietta D. Andre
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1870

8. AGE: Years 76 | Months 8 | Days 5 | If less than one day: hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business Self

FATHER
12. Name Dr. JAMES RIDGEWAY ANDRE
13. Birthplace DELAWARE (Seaford)

MOTHER
14. Maiden Name MARGARET MCCLONE
15. Birthplace DELAWARE

16 (a) Informant HOSPITAL RECORDS
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 13 1947 (Date received by Registrar)

Registrar Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 12, 1947, at 3:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10, 1947 to Feb. 12, 1947 and that I last saw h[illegible] alive on Feb. 12, 1947.

Immediate cause of death: CARDIAC DECOMPENSATION — Duration: 7

Due to: HYPERTENSIVE CARDIO-VASCULAR DISEASE — Duration: ?

Due to: — Duration:

Other Conditions: BRONCHOPNEUMONIA, RT. BASE — Duration: 3 days

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward H. Jones Jr. M. D.
Address Union Mem. Hosp. Date signed 2-12-47

VS 150

G13553 OC# G40982

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

81a

G13552 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimor
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 E. Madison St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Janice Rosphie Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Black | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-29-46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 1 | - | 12 | hr, min. |

9. Birthplace md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Hackett

13. Birthplace md.

MOTHER 14. Maiden Name Elizabeth Lee

15. Birthplace md

16 (a) Informant Reeder.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 2-14-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Baltimore, Md.

18 (a) Funeral director Maida Bosley

(b) Address 1421 E. Jefferson St.

19 (Date received by Registrar) FEB 13 1947 (Registrar) Huntington Holbrook, M.D.

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb 10 1947, at 10.53 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death: Pneumococcal Meningitis — Duration 5 hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. B. Taggart M. D.

Address Johns Hopkins Hospital Date signed 2-11-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48553

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G48553 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 27 N. Vincent St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 27 N. Vincent (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles Johnson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widower.

6 (b) Name of husband or wife: Lettie Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1897

8. AGE: Years: 50 | Months: 1 | Days: - | If less than one day: hr. min.

9. Birthplace Howard Co. Md.. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name George Johnson.

FATHER 13. Birthplace Howard Co. Md..

MOTHER 14. Maiden Name Millie Kelley.

MOTHER 15. Birthplace Howard Co. Md..

16 (a) Informant Sarah B. Sanders.

(b) Address 540 Oxford St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 13, 1947 (month) (day) (year)

(c) Cemetery or crematory W. Arlington Cem.

Location

18 (a) Funeral director Mrs. Katie P. Williams

Address 322 N. Schroeder St.

19 (a) 3 19 47 (Date rec'd by registrar) (b) Huntington Williams, M.D.

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb. 9 1947 at 9:45 A.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec. 24 1946 to Feb. 9 1947 and that I last saw h[illegible] alive on Feb. 9 1947.

Immediate cause of death: Cardiac Insufficiency — Duration: 6 hrs.

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. H. Watts M. D.

Address 515 Cathedral Date signed 2/11/47

VS 150

G18551 BC# G44565 G18554

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V122D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct are is especially important. Physicians; please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 937 W. Fayette St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** David Harrison

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 10 | 14 | hr. min. |

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name George Harrison
13. Birthplace Va

MOTHER
14. Maiden Name Sarah Norman
15. Birthplace Endfield N. C.

16 (a) Informant Sarah Harrison
(b) Address 937 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 14 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar
3 Feb 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/11 1947, at 3.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-7 1947 to 2-11 1947, and that I last saw h. alive on 2-7 1947.

| Immediate cause of death | Duration |
|---|---|
| Aspiration of Vomitus | 5 min |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation 2-11-47
Major findings of operation: Inflammatory mass in Stature with perforation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John C. Morrison M. D.
Address Univ. Hosp. Date signed 2-11-47

X

G43555

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G43555

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19 2
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 N. Mount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Miles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) ~~Single~~, married, ~~widowed, or~~ divorced. Married

6 (b) Name of husband ~~or wife~~ Blanche Brake

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years 43 | Months 12 | Days | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Alonza Miles
13. Birthplace Pocomoke City Md

MOTHER
14. Maiden Name Emma
15. Birthplace Va.

16 (a) Informant Mrs. Blanche Miles
(b) Address 6 N. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 14, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 822 W Lafayette St

19 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11, 1947 at 4 45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic pericarditis
Chronic valvulitis, mitral

Due to

Other Conditions Emphysema of lungs.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Green M.D.
Medical Examiner.
Date signed 2/12/47

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

G48556 **CERTIFICATE OF DEATH** ✓ 61 (Registered No.)

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1818 E. 31st Street
(c) Hospital or institution: 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 E. 31st Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** LENA ( CAROLINE ) FORREST

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William Edward For
6 (c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): Jan. 28, 1865

8. AGE: Years: 82 | Months: 0 | Days: 13 | If less than one day: hr. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Frederick Meyer
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Miss Gertrude Forrest
(b) Address: 1818 E. 31st Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/13/47 (month) (day) (year)
(c) Cemetery or crematory: Moreland Memorial Co.
Location: Baltimore - Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC
(b) Address: NORTH AVE. & BROADWAY

19 (a) Filed by registrar (b) Registrar: Huntington Williams, M.D.
2-18-1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: February 10 1947, at 1.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9 1947, to Feb 10 1947, and that I last saw h[illegible] alive on Feb 10 1947.

| | Duration |
|---|---|
| Immediate cause of death: Cardiac Failure | 12 hrs. |
| Due to: Diabetes Mellitus | Forty years. |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: James Graham Manton M. D.
Address: 5 E. Cathedral Date signed 2-13-47

X Other.

G48557

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48557 Registered No. 131 B

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
University Hospital 4 d
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Triangle Hotel, Hanover & Lombard
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

**3 (a) FULL NAME** ~~LOUIS~~ Louis A. JAMES

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, ~~married, widowed,~~ or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1st 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| (55) 50 | 7 | 10 | ....hr. ....min. |

9. Birthplace Saratoga Springs N. Y.
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER 12. Name Louis James
13. Birthplace Brooklyn N. Y.
MOTHER 14. Maiden Name Miriam Dowd
15. Birthplace North Granville N. Y.

16 (a) Informant Mr Wylly James
(b) Address Maplewood N. J.

17 (a) Burial [illegible] (b) Date [illegible] Feb 13
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Saratoga Springs N.Y.
Location N. Y.

18 (a) Funeral director Leo S. Cook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) ..... Huntington Williams, M.D. Registrar
(Date received by registrar)

FEB 13 1947
W 1ST

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 11th 1947 at 2:30 P. M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.....
Chronic nephritis.

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature William G. Helfrich, M.D. M.D.
Medical Examiner.
Date signed 2-13-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Geo. Shannon — Dobyns — G18558

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 107

Registered No. G18558

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3515 Menlo Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3515 Menlo Drive. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Ella Jw. Dobyns.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 8. 1868.

8. AGE: Years 79 | Months 1 | Days 4 | If less than one day hr. min.

9. Birthplace Lancaster Co. Va. (Town, county, and state)

10. Usual Occupation Retired Dressmaker

11. Industry or business

FATHER
12. Name Edwin Dobyns
13. Birthplace Lancaster Co. Va.

MOTHER
14. Maiden Name Catherine Saunders
15. Birthplace Lancaster Co. Va.

16 (a) Informant Mrs. Ora Guillams
(b) Address 3515 Menlo Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 15-1947 (month) (day) (year)
(c) Cemetery or crematory Bethel Cem.
Location Lancaster Co. Va.

18 (a) Funeral director Jeannie E. Lyfer.
(b) Address 1600 N. North Ave.

19 (a) (Date rec'd by registrar) FEB 13 1947 (b) Filed

VS 100

Huntington Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12. 1947, at 5 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5 1947 to Feb. 12 1947 and that I last saw h-r alive on Feb 10 1947

| Immediate cause of death | Duration |
|---|---|
| Bronchial Pneumonia (Primary) | |
| Due to | |
| Due to | |
| Other Conditions Senility. | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation

PHYSICIAN
Underline the cause to which death should be charged statistically.

of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dana E. Shannon M.D.
Address 520 medical Arts Bldg Date signed 2/13/47 M.D.

X

G18559

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G18559

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1236 S. Ellwood
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1236 S. Ellwood
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ANNA STEFAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24 1866

8. AGE: Years 80 | Months 6 | Days 17 | If less than one day hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name unknown
15. Birthplace Czechoslovakia

16 (a) Informant Mr. John Stefan
(b) Address 1236 S. Ellwood Ave

17 (a) Burial (b) Date thereof 2/14/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem
Location German Hill Road

18 (a) Funeral director Stephan Fiallowski & Co
(b) Address 1000 S. Ellwood ave

FEB 13 1947 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 151

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 2/10/47 19 , at 6:45 P.M.

**21.** I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John P. Evans M.D.
Medical Examiner.
Date signed 2/11/47

correct age is especially important. Physicians: please write the ... every item of information should be carefully supplied. The ... the causes of death clearly and legibly.

Dr Davies
2505 Rosalyn Ave

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

46F

Registered No. G13560

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address #6 North Gorman Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 W. Lorraine Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ida May Eckberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Henning S.
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Aug 23-1870

| 8. AGE: Years | Months | Days | If less than one day: hr. | min. |
|---|---|---|---|---|
| 76 | 5 | 19 | | |

9. Birthplace Baltimore Co., Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name George Mitzel
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Henning S. Eckberg
(b) Address 309 W. Lorraine Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 14-47 (month) (day) (year)
(c) Cemetery or crematory Clymo Laurel
Location Cockeysville Md

18 (a) Funeral director E. Haworth Armacost
(b) Address Liberty Heights Ave
(Date rec'd by registrar) FEB 13 1947 Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 11 1947, at 9.10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 15 1947, to Feb. 10 1947, and that I last saw h.e. alive on Feb. 10 1947

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of liver | 6 Mo. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Arthur J. Davies, M. D.
Address 2-13-47 Date signed

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. 038561

038561

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd St. & Stafford Ave.
(c) Hospital or institution: Union Memorial Hospital 12-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) ?

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2725 N. Charles St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** IRENE C. E. SCHEFFENACKER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charles J. Scheffenacker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 27, 1877

8. AGE: Years 69 | Months 7 | Days 16 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: None
11. Industry or business

FATHER
12. Name: Pierre Gaspani
13. Birthplace: France

MOTHER
14. Maiden Name: Mary Preston
15. Birthplace: Baltimore, Md.

16 (a) Informant: Hospital records.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/47 (month) (day) (year)
(c) Cemetery or crematory: Cathedral Cem.
Location: Baltimore, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) 1947

FEB 13

Certificate for William Maxwell Hosp.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 13, 1947, at 2 04 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 30, 1947 to Feb. 13, 1947; and that I last saw him alive on Feb. 13, 1947.

Immediate cause of death: Cerebral hemorrhage — Duration: 14 days

Due to: Hypertensive cardio-vascular disease — ?

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Edward H. Jones Jr. M. D.
Date signed 2-12-47

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18562

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G18562 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4230 Loch Raven Blvd.
(c) Hospital or institution: Northwood Apts.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-9
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4230 Loch Raven Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** JOHN A. RUSSELL

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 219-16-5275

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife: Theresa Russell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 3 | 6 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired Pharmacist
11. Industry or business

FATHER
12. Name Alexander Russell
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah E. Baker
15. Birthplace Md.

16 (a) Informant Mrs. Eunice R. Rogge
(b) Address 4230 Loch Raven Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 13 1947 (Date received by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 12 1947, at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945 to Feb. 12 1947, and that I last saw him alive on Feb. 12 1947

| Immediate cause of death | Duration |
|---|---|
| Hypostat. Pneumonia | 3 days |
| Cardiac Failure | |
| Due to Cerebral Hemorrhage | 4 days |
| Due to Hypert. Cardiovascular disease | Several years |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred S. Ledermann M. D.
Address 3E. Preston Street Date signed 2/12-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

C48563 / 61 C48563

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2134 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2134 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: CHARLES H. PHELPS

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife: Rhoda Phelps
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 7 | 28 | hr. min. |

9. Birthplace: Richmond, Va. (Town, county, and state)
10. Usual Occupation: Retired Electrician
11. Industry or business

FATHER
12. Name: John Phelps
13. Birthplace: Richmond, Va.

MOTHER
14. Maiden Name: Malissa Cook
15. Birthplace: Richmond, Va.

16 (a) Informant: Mrs. Rhoda Phelps
(b) Address: 2134 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/47 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar's No.

FEB 13 1947

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 12 1947; at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Feb. 12 1947, and that I last saw h.im. alive on Feb. 12 1947.

Immediate cause of death: Diabetes Mellitus — Duration: 8 mos.

Due to:

Due to:

Other Conditions: Gangrene, R. Foot

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: C. W. Hoffman M.D.
M. D.
Address: 8 East Read St Date signed 2/13/47

X

AB-107860 G18564

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 92 c

Registered No. G18564

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: 9-2
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19days
(e) Length of stay in Baltimore (yrs., mos., or days) 45yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2050 E. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Fred. August Mueller

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | White | Married |

6 (b) Name of husband or wife Agnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9- 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 5 | 2 | hr. min. |

9. Birthplace Texas.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Andrew Mueller
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Lynch
15. Birthplace Pa.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-15-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Blair Road

18 (a) Funeral director Oster Funeral Home Inc.
(b) Address 402 E-25th St.

19 (c) 1947 Huntington Williams M.D. Registrar
(Date received by registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11- 1947, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-23 1947 to 2-11 1947 and that I last saw h 12 alive on 2-11- 1947.

| Immediate cause of death | Duration |
|---|---|
| Congestive Heart Failure | |
| Due to Rheumatic Aortic Disease | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert R. Farber M. D.
Address Balto. City Hosp. Date signed 2-11-47

X

G18565

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G18565 X 13 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Calif. (b) County
(c) City or town San Francisco (If outside city or town limits, write RURAL and give town)
(d) Street No. 2110- 22nd Ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** O'Keefe, John Edward

3 (b) If veteran, name war

3 (c) Social Security Account No. 546-16-3407

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1897

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 49 | 5 | 27 | hr. min. |

9. Birthplace San Francisco, Calif. (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Seafarer

FATHER 12. Name Wm. O'Keefe
13. Birthplace Ireland

MOTHER 14. Maiden Name Bridgett Melia
15. Birthplace Ireland

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-47 (month) (day) (year)
(c) Cemetery or crematory Potters Interfaith
Location 5724 York Road Cemetery

18 (a) Funeral director Acker Funeral Home Inc.
(b) Address 402-E-25th St.

19 (a) FEB 13 1947 (Date received by registrar) (b) Huntington Williams, Md. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 11 1947, at 8:25A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5 1947 to Feb. 11 1947 and that I last saw him alive on Feb. 11 1947.

Immediate cause of death Tuberculosis pulmonary, bilateral, far advanced — Duration UNKNOWN

Due to — over

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 2/12/47

X

C18566
CMK-108390

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. C18566

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitlas
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 No. Port Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anna Henrietta Bransby

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife John (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 16-1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 0 | 27 | hr. min. |

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Packer
11. Industry or business Md. Glass Corp.

FATHER
12. Name William Seaderer
13. Birthplace Germany

MOTHER
14. Maiden Name Clara Siemnough
15. Birthplace Germany

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 2/15/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 14 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH February 13 1947, at 8:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1947 to Feb. 13 1947 and that I last saw her alive on Feb. 13 1947.

| Immediate cause of death | Duration |
|---|---|
| Coma — Malignancy | 1 day |
| Pulmonary Infarct | 1 day |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. A. Williams M.D.
Address Baltimore City Hosp. Date signed 15 Feb 47

X

618567

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. 618567

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lexington St
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 Fairmount Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** John C. Holzemer

3 (b) If veteran, name war: no
3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Olivia M. Holzemer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 29 1874

8. AGE: Years 73 | Months 0 | Days 13 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name John C. Holzemer
FATHER 13. Birthplace Germany
MOTHER 14. Maiden Name Unknown
MOTHER 15. Birthplace Germany

16 (a) Informant Louise Baker
(b) Address 404 S. Eaton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 15 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Wm. Cook Inc
(b) Address 1217 St Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 14 1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 12 1947, at 10 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1946 to Feb 12 1947 and that I last saw [illegible] alive on Feb 12 1947.

Immediate cause of death
General Arteriosclerosis
Chronic myocarditis

| | Duration |
|---|---|
| Due to | 5 yrs |
| Due to | 5 yrs |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton L. Solomon
Address 129 S Bway Date signed 2/13/47 D.

X

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

CM-697647 68 — 307 — Registered No. 16868

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-2-9-
(e) Length of stay in Baltimore (yrs., mos., or days) 27 Years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 527 Hoffman Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Thomas Kenny

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ??

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| ? 43 | | | hr. min. |

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER — 12. Name Frank Kenny
13. Birthplace North Carolina

MOTHER — 14. Maiden Name Angeline ?
15. Birthplace North Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-15-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) [illegible] (b) [illegible] Registrar
(Date received by Registrar) [illegible] Lexington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** February 12 1947, at 5 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec. 3 1945, to Feb. 12 1947 and that I last saw h. imalive on Feb. 12 1947

Immediate cause of death — Duration
Cerebral Hemorrhage — yrs? mos? days?
Due to Luetic Endarteritis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy: An abstract

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Robinson Jr. M. D.
Address Balt. City Hosp. Date signed 2/13/47

X

G48569

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. G48569

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 512- Bloom St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 512- N. Bloom St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

**3 (a) FULL NAME** George Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb. 10, 1947 at 9 P. M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2-9-1947 to 2-10-1947, and that I last saw him alive on 2-10-1947.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | Colored | Widower |

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | | | hr. min. |

9. Birthplace Gloucester Co. Va. (Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER — 12. Name Brayton Washington
13. Birthplace Virginia

MOTHER — 14. Maiden Name Mollie Carter
15. Birthplace Virginia

16 (a) Informant Henrietta Fraser
(b) Address 915 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director C. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

FEB 14 1947
VS 150

| Immediate cause of death | Duration |
|---|---|
| Cardio-Vascular Renal Disease, Acute Myocarditis | 1 yr |
| Due to failure | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23.** Signature H. H. Jackson

Address 620 N. Arlington Ave. Date signed 2/13/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48570

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1214

G48570 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 25 N. Luzerne Street
(c) Hospital or institution: - - - - - -
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 25 N. Luzerne St.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Poland

**3 (a) FULL NAME** Rose Fibich (Faby)

3 (b) If veteran, name war - - -
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widowed |

6 (b) Name of husband or wife Andrew Fibich
6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) 5-10-1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 9 | 1 | ..... hr. ..... min. |

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Malach ?
13. Birthplace Poland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Poland

16 (a) Informant James Fibich
(b) Address 25 N. Luzerne St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 - 14-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Wolfe Street

19 (a) FEB 14 1947 (Date received by registrar) (b) Huntington Williams, M.D.

V S 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 11 1947, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May - 1939 to Feb 11 - 1947, and that I last saw h[illegible] alive on Feb 11 - 1947

| Immediate cause of death | Duration |
|---|---|
| Myocardial Insufficiency | 2 days |
| Due to Chronic Interstitial Nephritis | 8 yrs |
| Due to Arteriosclerosis | |
| Other Conditions Acute Cystitis | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 156 N. Wolfe St. Date signed 2/14/47

X

G48571

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G48571

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the... the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Eaton Ave
(c) Hospital or institution St Agnes Hospt 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3409 Callaway Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Richelson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Fannie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-14-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia & Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1432 E. Baltimore St.

19 (a) [illegible] Huntington Williams, Mortician
(Date rec'd by reg.) Registrar

FEB 14 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-13 1947 at 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-11 1947 to 2-13 1947, and that I last saw him alive on 2-13 19

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | — |
| Cardiac failure | |
| Due to Hydrothorax right | |
| Due to | |
| Other Conditions Hypertensive and Arteriosclerotic Heart Disease (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry M. Hodges M. D.
Address St. Agnes Hospital Date signed 2-13-47

X

G18572

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G18572

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood + Greene Sts.
(c) Hospital or institution: University 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 542 N. Carey St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

**3 (a) FULL NAME** Josephine Pegram

3 (b) If veteran, name war: Ns
3 (c) Social Security Account No.: None

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | Col. | Married |

6 (b) Name of husband ~~or wife~~ Frank
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/11 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 8 | 7 | hr. min. |

9. Birthplace Blackstone Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Washington Pelegar
13. Birthplace Blackstone Va

MOTHER
14. Maiden Name Mary Sheet
15. Birthplace Blackstone Va

16 (a) Informant Walter Pegram (Son)
(b) Address 542 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/16/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Fitzgerald
Location Blackstone, Va.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 8 1947 at 1.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 30 1947 to Feb 8 1947 and that I last saw her alive on Feb 8 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure | |
| Due to Coronary occlusion | 10 days. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gerald A. Martin M. D.
Address University Hosp. Date signed 2-10-47

VS FEB 14 1947 Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48573

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1318

Registered No. G48573

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2644 Pennsylvania Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2644 Pennsylvania Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** BERNARD JOSEPH WALLENHORST

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ruth May Wallenhorst (nee Whitlock)

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 3, 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 10 | 9 | hr. min. |

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: none

11. Industry or business:

**FATHER**
12. Name: Augustus Wallenhorst
13. Birthplace: Md.

**MOTHER**
14. Maiden Name: Marie Ells
15. Birthplace: Md.

16 (a) Informant: Mrs. Ruth M. Wallenhorst
(b) Address: 2644 Pennsylvania Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/47 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date received by registrar) FEB 14 1947 Registrar

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12, 1947, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 14, 1947 to Feb. 12 1947 and that I last saw h[illegible] alive on Feb. 11 1947.

| Immediate cause of death | Duration |
|---|---|
| Chr. Myocarditis. | |
| Due to | |
| Due to | |
| Other Conditions Chr. Nephritis | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Geo. E. Shannon M. D.
Address 820 Medical Arts Bldg. Date signed 2/13/47

X

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

509847 018571 / 1310 Registered No. 018571

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 19

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 208 N. Mount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Grace Hughes

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Black | Married |

6 (b) Name of husband or wife. John Hughes
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-28-04

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 45 | 3 | 16 | hr. min. |

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Lewis
13. Birthplace Va.

MOTHER 14. Maiden Name Rosalia Broad
15. Birthplace Va.

16 (a) Informant Mr. John Hughes
(b) Address 208 N. Mount St.

17 (a) Burial (b) Date thereof Feb. 16, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Gebutes Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George D. Hallard
(b) Address 637 Druid Hill Ave

19 (a) (b)
(Date rec'd by registrar) Huntington Williams, M.D.

VS FEB 14 1947

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb 13 1947, at 9:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1947 to Feb. 13 1947 and that I last saw her alive on Feb 12 1947.

| Immediate cause of death | Uremia | Duration Not known |
|---|---|---|
| Due to | Nephritis chronic | Nursen |
| Due to | Hemiplegia | |
| Other Conditions | Hypertension | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo Hallard M.D.
Address Johns Hopkins Date signed 2/13/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the

G48575

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

131a

Registered No. G48575

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1219 Division St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1219 Division St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Florence M. Mason

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Charles
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 2, 1881
8. AGE: Years 65. Months 5 Days 8 If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name
13. Birthplace Unknown

MOTHER
14. Maiden Name
15. Birthplace Unknown

16 (a) Informant Florence Stucy
(b) Address 1219 Hilmuth St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 14, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director George H. Holland
(b) Address 1631 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 14 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 10, 1947 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1946 to Feb 10, 1947 and that I last saw h[illegible] alive on Feb. 10, 1947.

Immediate cause of death: Cardio-vascular Renal disease — Duration

Due to: Arteriosclerosis

Due to:

Other Conditions: None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. A. Hawkins M. D.
Address 1212 Druid Hill Ave Date signed

X

G48576

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

95c

Registered No. G48576

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 204 E. Federal St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 204 E. Federal St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Samuel H. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-16-3983

4 Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Eleanor F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1870

8. AGE: Years 76 | Months 5 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Hezekiah Brown
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Ann Fowler
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Eleanor F. Brown
(b) Address 204 E. Federal St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 14, 1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Chas. H. Holland
(b) Address 1613 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 14 1947 Huntington Williams, M.D.

V S 130

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1947, at 9 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 1947, to 2/11 1947, and that I last saw h... alive on 2/11 1947.

Immediate cause of death: Coronary Thrombosis — Duration 1 day

Due to: Chronic Hypertension

Due to: Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Higgins M. D.
Address 247 Madison Ave Date signed 2/13/47

X

G13577

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

61

Registered No. G13577

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 Gwynns Falls Pkwy
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Bertha Goodman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Israel Goodman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 1876

8. AGE: Years 70 | Months 2 | Days | If less than one day: hr. min.

9. Birthplace: Bath, Md.
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Levi Mandlebaum
13. Birthplace: Germany

MOTHER
14. Maiden Name: Regina Cohen
15. Birthplace: Germany

16 (a) Informant: Mrs. L. Mandlebaum
(b) Address: 1719 Gwynns Falls Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2/14/47 (month) (day) (year)
(c) Cemetery or crematory: Balto. Hebrew
Location: Balto. Md.

18 (a) Funeral director: Chas. Sonneborn & Son
(b) Address: 1902 Eutaw Place

19 (a) FEB 14 1947 (Date received by Registrar) (b) Huntington Williamsburg, Md. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/13 1947, at 7:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/29 1946 to 2/13 1947, and that I last saw h[illegible] alive on 2/13 1947.

| Immediate cause of death | Duration |
|---|---|
| Resp. failure | |
| Due to Bronchopneumonia | |
| Due to | |
| Other Conditions Senile arteriosclerosis Diabetes mellitus C.V.A. (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Sidney Green M. D.
Address: Sinai Hospital Date signed: 2/13/47

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G13578 (1937) Registered No. G13578

G13578

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1014 N. P.P.K ave
(c) Hospital or institution: Mercy Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wk
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 N. Patterson Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lester H. Cline

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Catharine A. Cline

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Apr 20 1890

8. AGE: Years 56 | Months 9 | Days 21 | If less than one day ____hr. ____min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Penny R R Co

11. Industry or business General

FATHER
12. Name Lincoln Cline
13. Birthplace Pa

MOTHER
14. Maiden Name Nettie Sounders
15. Birthplace Pa

16 (a) Informant Catharine Cline
(b) Address 1014 N. P.P.K Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 17th (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 E. Oliver St

19 (a) (Date received by registrar) FEB 14 1947 Registrar Huntington Williams, M.D.

VS 191

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1947, at 5:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to Hypertensive C.V. Disease

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Lubinski M.D.
Medical Examiner.
Date signed 2/11/47

X

Every item of information should be carefully supplied, with UNFADING INK. Every item of information should be carefully supplied, with UNFADING INK. Every item of information should be carefully supplied, with UNFADING INK.

G13579

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 61 ✓

G13579 Registered No.

Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 612 E. 36th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County A. A. Co.
(c) City or town Ritchie Highway
(If outside city or town limits, write RURAL and give town)
(d) Street No. Morris Hill
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Genera Gischel

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | married |

6 (b) Name of husband or wife John Gischel
6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) July 9, 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 7 | 4 | hr. min. |

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Edna Kornmayer
(b) Address 612 E. 36th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/ 14/ 47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd

18 (a) Funeral director John F. Wenning Sons Co.
(b) Address 748 Light St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS FEB 14 1947

Hunting for Mr. Genera

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Febr. 13 1947, at 12:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/24 1947 to 2/13 1947, and that I last saw her alive on 1/24 1947

| Immediate cause of death | Duration |
|---|---|
| Hypostatic pneumonia | 5 days |
| Due to diabetic gangrene | 5 mos |
| Due to diabetes mellitus | 12 y. |
| Other Conditions Left hemiplegia. | 1/4. |
| Generalized arteriosclerosis | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julius Lobe M. D.
Address 3730 Pearhurst Rd. Date signed 2/13/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please ... write the causes of death clearly and legibly.

648580

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

469

Registered No. 648580

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 739 N. Kenwood Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Doris E. WEST

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-16-8052

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or ~~wife~~ Richard Allen West

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 26, 1922

8. AGE: Years 24 yrs | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Western Electric

FATHER
12. Name Raymond Siegmund
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Eva Hazelbeck
15. Birthplace Baltimore, Md.

16 (a) Informant Richard Allen West - husband
(b) Address 739 N. Kenwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Baltimore
Location North Ave. & Rose St. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) Filed [illegible] 1947
(b) Registrar [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/11/47 at 1:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/4/47 to 2/11/47 and that I last saw h[illegible] alive on 2/11/47

| Immediate cause of death | Duration |
|---|---|
| Cardio-respiratory failure | |
| Due to post operative shock | |
| Due to Malignancy - upper right abdomen. Duodenum | over |
| Other Conditions Kochs infection | |

(Include pregnancy within 3 months of death)

Date of operation 2/11/47

Major findings of operation: Malignancy upper right abdomen [illegible]

of autopsy:

PHYSICIAN
Underline the cause to which [illegible] should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 2/11/47

VS 190

—X

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G48581 — Registered No. G48581

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 610 N Luzerne Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and name town)
(d) Street No. 610 N Luzerne St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Conrad Sponsal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Bertha (nee Yrick)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 17, 1874

8. AGE: Years 72 | Months 7 | Days 24 | If less than one day ____hr. ____min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation: retired

11. Industry or business

FATHER
12. Name: unknown
13. Birthplace: "

MOTHER
14. Maiden Name: "
15. Birthplace: "

16 (a) Informant: Mrs. Berthan Sponsal - wife
(b) Address: 610 N. Luzerne Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/47 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: North Ave. & Rose St. Balto. Md.

18 (a) Funeral director: Charles E. Schimunek
(b) Address: 2601 E. Madison Street

19 (a) FEB 14 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Feb 11th 1947, at 2:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Hes death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Coronary Occlusion

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: William H Kelbach M.D. Medical Examiner
Date signed 2/12/47

BEAMAN

G48582 ✓ G48582

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Church Home - North Broadway
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs Mary Shewer Parker Beaman

3 (b) If veteran, name war —

(c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | white | Widowed |

6 (b) Name of husband or wife Mr Wm. Beaman.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 27, 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 8 | 23 | hr. — min. |

9. Birthplace Salem N. J.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Joseph Benson Parker.
13. Birthplace Bloomfield - Pa

MOTHER
14. Maiden Name Margaret York.
15. Birthplace Salem N.J.

16 (a) Informant Mrs Sidney McKenzie
(b) Address Wayne Penn

17 (a) Cremation (b) Date thereof Feb 14 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry W. Jenkins & Sons
(b) Address McCulloh - Orchard Sts

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150 FEB 14 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1947 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to Feb 13 1947 and that I last saw h[illegible] alive on Feb 13 1947

| Immediate cause of death | Duration |
|---|---|
| Cardiac insufficiency | 4 hrs. |
| Due to Arteriosclerotic heart disease. | 10 yrs. |
| Due to | |
| Other Conditions Arteriosclerosis general | 10 yrs |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address Cor. N. Howard & Centre Date signed 2/13/47

X

G13583

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46B

Registered No. G13583

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 529 S. Pat St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Catherine Maliñowski

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mr. Stanislaus

6 (c) If alive, give age ) years

7. Birth date of deceased (mo., day, yr.) April 8 1878

8. AGE: Years 68 | Months 10 | Days 13 5 | If less than one day ___hr. ___min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Mr John FERENC
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Dzogh
15. Birthplace Poland

16 (a) Informant Patient
(b) Address

17 (a) Burial (b) Date thereof 2-17-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS
Location Baltimore Md.

18 (a) Funeral director George A. Weber
(b) Address 405 S Eutaw St

19 (a) (Date received by Registrar) FEB 14 1947 Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 13 1947, at 9:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-27- 1947, to 2-13- 1947, and that I last saw her alive on 2-13- 1947

| Immediate cause of death | Duration |
|---|---|
| Heart failure | 2 hrs |
| Due to Carcinoma of stomach | |
| Due to Metastasis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ina F. Jadan M. D.
Address Church Home Hospital Date signed 2-17-47

G48581

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93

G48584 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1318 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Frazier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9, 1895

8. AGE: Years 51 50 | Months 5 | Days 3 | If less than one day hr. min.

9. Birthplace Savannah, Chatham, Georgia (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Lillian Jones (Daughter
(b) Address 1318 W. Mulberry st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof February 17, 1947 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Cemetery
Location Baltimore city

18 (a) Funeral director Joseph A. Lively
(b) Address 661 West Baltimore Street

19 FEB 14 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/12 1947, at 6:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions Malnutrition

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Talbert M.D.
Medical Examiner.
Date signed 2/13/47

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43585

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 927

Registered No. G43585

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Seyon Fayette Sts.
(c) Hospital or institution Bon Secour Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Weeks
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 314 S. Collins Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs. Ethel M. Schaeffer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~ |
|---|---|---|
| Female | W | |

6 (b) Name of husband ~~or wife~~ Leo Schaeffer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26, 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 4 | 18 | hr. min. |

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name William A. Brice
13. Birthplace Charlestown, Md.

MOTHER
14. Maiden Name Katie D. Harney
15. Birthplace Md.

16 (a) Informant Mrs. Leo F. Schaeffer
(b) Address 314 So. Collins Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Road
18 (a) Funeral director John J. Bowen & Son
(b) Address 1417 & 1419 Eutaw Street

FEB 14 1947 (Date rec'd by registrar)

(b) Registrar Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/13/47 19 at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 4 1946, to Feb 13 1947, and that I last saw her alive on Feb 12 1947.

Immediate cause of death Cardiac failure — Duration 2 mos.
Due to Generalized arteriosclerosis & arteriosclerotic heart disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E. Farlee M. D.
Address Bon Secour Hosp, Balto. Date signed 2-15-47

VS 150

X

G13786 BCH THIS PON

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 157E

509715 F97247 Registered No. G12536

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 139 S. Catherine St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Judith [illegible] Riggen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-5-44

8. AGE: Years 2. | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Wm J Riggen
13. Birthplace Md.

MOTHER
14. Maiden Name Anne Bowman
15. Birthplace N. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (burial, cremation, or removal) (b) Date thereof 2/15/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Reed Ave

18 (a) Funeral director John J Bowman Son
(b) Address 901-03 Gallows St

19 (a) Filed FEB 1 1947 (b) Registered [illegible]

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb - 12 1947 at 8.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb - 10 1947 to Feb 12 1947 and that I last saw her alive on Feb - 12 1947.

Immediate cause of death: Cerebral Thrombosis — Duration 7 hours

Due to: Tetralogy of Fallot — Congenital

Due to:

Other Conditions: R. Blalock operation

(Include pregnancy within 3 months of death)

Date of operation 2/12/47

Major findings of operation: Congenital heart disease

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. C. Sanford M.D.
Address Johns Hopkins Hosp Date signed 2/13/47
Baltimore Md.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 618587 (also 618587) 1220

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Edmund + Saratoga Sts.
(c) Hospital or institution: Bayview Hosp. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) Never
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 660 Aisquith St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME PAULINE WELSH

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | B | Widow |

6 (b) Name of husband or wife James Welsh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24 1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | 2 | 17 | hr. min. |

9. Birthplace Balto, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Frank Conath
13. Birthplace Balto.

MOTHER
14. Maiden Name Lizzie Brown
15. Birthplace Balto.

16 (a) Informant Ruth Kane
(b) Address 1114 Woodyear St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 17 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Wis Ave & R. Williams
18 (a) Funeral director Wm Kane R. Williams
(b) Address 3229 W. Belvedere St.
19 (a) Registrar FEB 14 1947 (b) Huntington Williams M.D.

VS 130

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 12 1947, at 7 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Feb 5 1947 to Feb 12 1947 and that I last saw h[illegible] alive on Feb 12 1947

| Immediate cause of death | Duration |
|---|---|
| Peritonitis | |
| Due to Rupture of Intestines | |
| Due to Strangulated Hernia | |
| Other Conditions Diabetes Mellitus | |

(Include pregnancy within 3 months of death)
Date of operation Feb 5 1947
Major findings of operation: Strangulation of bowel in hernia
If autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. O'Hare M.D.
Address Bayview Hosp. Date signed 2/13/47 M. D.

J. O'HARE, M.D.

G48588 ✓ G48588

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 54a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 129 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 823 Edmundson Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** William T. Wagner

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Negro | Married |

6 (b) Name of husband or wife Mary Wagner
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) May 28, 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 8 | 15 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name William Wagner
13. Birthplace Md.

MOTHER
14. Maiden Name Blanche Colton
15. Birthplace Va.

16 (a) Informant Mary Wagner
(b) Address 823 Edmondson Ave.

17 (a) Burial (b) Date thereof Feb. 15, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs. Estie R. Williams
(b) Address 2229 W. Schroeder St.

19 FEB 14 1947 (b) Huntington Williams, M.D.
(Date filed by Registrar) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 12 1947, at 9:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29 1946 to 2-12-1947, and that I last saw him alive on 2-12-1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Neoplasm | |
| Due to | |
| Due to | |
| Other Conditions Pul. edema & Congestion. Dehydration | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Grossey M.D.
Address 1517 Eutaw Pl. Date signed 2/15/47

G18589

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G18589

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert
(c) Hospital or institution: Henry Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3409 Greenmount (If rural give locality)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Russell Craft

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Widowed |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB 22, 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 11 | 20 2/2 | hr. min. |

9. Birthplace Illinois (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name William Henry Craft

13. Birthplace Illinois

MOTHER 14. Maiden Name Jane Westman

15. Birthplace Illinois

16 (a) Informant Sarah M. Johnston

(b) Address 219 Wyman Park Apts

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Feb. 17 (month) (day) (year) 1947

(c) Cemetery or crematory London Park

Location 3891 Frederick ave

18 (a) Funeral director John O. Mitchell Home

(b) Address 1900 Eastern Place

19 (a) Filed FEB 14 1947 (b) Registrar Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-14 1947, at 3 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-12 1947 to 2-14 1947 and that I last saw h. alive on 2-14 1947.

| Immediate cause of death | Duration |
|---|---|
| Myocardial infarction | 2 days |
| Due to Coronary Arteriosclerosis | ? |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature
Address Henry Mem Hosp Date signed 2-14-47 M. D.

X

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

Registered No. 613590

12590

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1504 E. Lanvale Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 E. Lanvale Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** LOUIS FREDERICK KRAMER

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Helena Albina Kramer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1861

8. AGE: Years 85 | Months 2 | Days 28 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business

**FATHER**
12. Name: Frederick Kramer
13. Birthplace: Baltimore, Maryland

**MOTHER**
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Dr. Edward W. Stieff
(b) Address: 1504 E. Lanvale Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/ 12/47 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) FEB 14 1947 (Registrar's signature) Huntington Williams M.D.

VS 150

**MEDICAL CERTIFICATION** A. M.

20. DATE OF DEATH February 12 1947, at 9.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1947 to Feb 12 1947
and that I last saw h[illegible] alive on Feb. 11 1947

Immediate cause of death: Coronary occlusion — Duration: 48 hrs
Due to: Arteriosclerotic C-V disease
Due to:
Other Conditions: Senility
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: W. H. Kramer
Address: 1402 E Lanvale St. Date signed: 2.15.47.

G18391

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 927

Registered No. G18591

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1626 Chilton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 Chilton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Hinton Todd

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Edward H. Todd

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/26/1872

8. AGE: Years 74 Months 4 Days 16 If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

MOTHER | FATHER

12. Name Geo H. Stinemetz

13. Birthplace Baltimore Md

14. Maiden Name Emma Hinton

15. Birthplace Baltimore Md

16 (a) Informant Mrs E. H. Todd

(b) Address 1626 Chilton St

17 (a) Burial (b) Date thereof 2-14-47
(burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Laurel Cem.

Location Edmondson Road

18 (a) Funeral director J. B. Baker Sons

(b) Address 1318 Light St.

19 (a) Date received FEB 14 1947 (b) Huntington Williams, M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 11 1947 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1946 to Feb 11 1947 and that I last saw her alive on Feb 11 1947.

Immediate cause of death: Coronary thrombosis

Due to: Valvular heart disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: 6 hrs. 3 yrs.

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. J. Van Ness

Address 1618 Randall St Date signed 2/14/47 M. D.

G48592 ✓ BALTIMORE CITY HEALTH DEPARTMENT Registered No. G48592

CHK-108977

# CERTIFICATE OF DEATH 107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 51- 7- 8-

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 Washington Boulevard (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Henry Sohadel

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-03-1913

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Annie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4-1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | 7 | 8 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Truck Helper
11. Industry or business Yacht Bros.

FATHER
12. Name Henry Sohadel
13. Birthplace Maryland

MOTHER
14. Maiden Name Sakly Faile
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (b)
FEB 14 1947
Huntington Williams Mgr.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12 19 47 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 19 47 to Feb. 12 19 47, and that I last saw him alive on Feb. 12 19 47.

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions Possible Cerebral vascular accident

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Dayle Waldron M. D.
Address BCH Date signed 2-12-47

Howard S. Mosher, M.D. X.

G48593

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G48593 Registered No.

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline

(c) Hospital or institution: St Josephs Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) One

(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

Street No. 209 S. East Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Elizabeth J. Britcher Britcher

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23 1879

8. AGE: Years 67 | Months 8 | Days 21 | If less than one day hr. min.

9. Birthplace Kent Co Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Thomas Newcomb

13. Birthplace Kent Co Md

MOTHER 14. Maiden Name Matilda Cook

15. Birthplace Kent Co Md

16 (a) Informant Mrs H Britcher

(b) Address 209 E Cook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/47 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore Md

18 (a) Funeral director Wilson & Hoffman

(b) Address 1217 E Fond St

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2-14- 1947 at 6.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-13 1947 to 2-14 1947 and that I last saw her alive on 2-13 1947

Immediate cause of death Coronary Artery

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Nathan Kaminsky M. D.

Address 1st for. Hospital Date signed 2/14/47

VS 150 FEB 14 1947 Huntington Williamsport, Md.

G48591

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G48594

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4000 Fairfax Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4000 Fairfax Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** WILLIAM C. NOEL

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Annie E. Noel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 8 | 15 | hr. min. |

9. Birthplace Frostburg, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Real Estate

FATHER
12. Name James H.
13. Birthplace England

MOTHER
14. Maiden Name Julia Wagner
15. Birthplace Md.

16 (a) Informant Miss Jewel Noel
(b) Address 4000 Fairfax Rd.

17 (a) Burial (b) Date thereof 2/15/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Filed by FEB 14 1947 Registrar
V S 150

Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 13, 1947, at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 11 1947 to Feb. 13 1947 and that I last saw him alive on Feb. 11 1947

| Immediate cause of death | Duration |
|---|---|
| 1 Acute myocarditis | |
| Due to Coronary thrombosis | 10 years |
| Due to hypertension | |
| Other Conditions none | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Charles S. Meistadt M. D.
Address 1730 Linden ave Date signed 2/14/47

X

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 618595

618595 92a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1641 Hanover St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1641 Hanover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

**3 (a) FULL NAME** William H. Harnsberger

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | widowed |

6 (b) Name of husband or wife Mary Craig Lee
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Oct 14, 1844

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 92 | 3 | 29 | hr. min. |

1854

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Stephen Harnsberger
13. Birthplace Unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Stephen Harnsberger
(b) Address Unknown

17 (a) Burial (b) Date thereof 2/17/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director John F Denny Inc
(b) Address 21 E Eight St.

19 (a) (b)
(Date rec'd by registrar)

VS 150 FEB 14 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 13 1947 at 10 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/8 1947 to 2/13 1947 and that I last saw him alive on 2/13/47 19

Immediate cause of death Cerebral and general arterio sclerosis

Duration 2 y

Antecedent cause of hemorrhage

Due to Infirmity

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Lovell M.D.
Address 216 Hanover St. Date signed 2/14/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

618596

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 124B

Registered No. C18596

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 805 Whatcoat St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Porter, John Henry

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Louise Porter
6 (c) If alive, give age 24 years
7. Birth date of deceased (mo., day, yr.) 1907
8. AGE: Years 40 yrs Months - Days - If less than one day hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Rensay Porter
13. Birthplace -

MOTHER
14. Maiden Name Martha
15. Birthplace -

16 (a) Informant Wife
(b) Address 805 Whatcoat St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. Co. Md.
18 (a) Funeral director Metropolitan Funeral Home Inc.
(b) Address 927 N. Monroe St.

FEB 14 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13 1947, at 8:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 17 1947 to Feb 13 1947 and that I last saw him alive on Feb 13 1947

Immediate cause of death: Atrophic Cirrhosis of liver — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cirrhosis of liver, Probable Ca. of Pancreas

**PHYSICIAN**
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Th. B. Cooley M. D.
Address Date signed 2/17/47

VS 150

G18597

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G18597

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT PLAINLY, WITH UNFADING INK.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3015 Hudson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 3015 Hudson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry A. Spicer

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Margaret M. Spicer

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) June 26 1871

8. AGE: Years 75 | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Boiler Iron - Metal Co

11. Industry or business

FATHER
12. Name Adolphus Spicer
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mc Kenney
15. Birthplace "

16 (a) Informant Margaret M Spicer
(b) Address 3015 Hudson St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2-17-47 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Old Depot St

18 (a) Funeral director John E Milby Inc
(b) Address 2425 E Oliver St

19 (a) FEB 14 1947 (Date rec'd by registrar) (b) Huntingtown Williamsport Md

VS 181

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1947, at 7:45 A M

21. I certify that I took charge of the remains described above, held an Autopsy on Thursday thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular

Due to disease -

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Kelfrich M.D. Medical Examiner
Date signed Feb 13 1947

G18598

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46F

Registered No. G18598

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 85 days
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 E. Chase St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Gyorfi, Alexander

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Marie Vechil Gyorfi
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1899

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 47 | 4 | 8 | ....hr. ....min. |

9. Birthplace Hungary (Town, county, and state)
10. Usual Occupation Radio operator
11. Industry or business Seafarer

FATHER
12. Name Alexander Gyorfi
13. Birthplace Hungary

MOTHER
14. Maiden Name Anna ?
15. Birthplace Hungary

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 15th 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Road

18 (a) Funeral director Leo G. Leach
(b) Address 1201-03 N. Pattison Park Ave

19 (a) ....(Date rec'd by registrar) (b) Williamsport, Md.

VS FEB 14 1947 Cottington

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 13 1947, at 4 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20 1946 to Feb. 13 1947 and that I last saw him alive on Feb. 13 1947

| Immediate cause of death | Duration |
|---|---|
| Primary adeno-Carcinoma of liver | 5 mos. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 12-17-46
Major findings of operations Primary adenocarcinoma of liver
of autopsy: None done

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ....at ....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Willys M. Monroe
Willys M. Monroe M. D.
Address S.A. Surgeon Date signed 2/13/47

X

G18599

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 178a

G18599 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1803 N. Dallas st.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Don
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 N. Dallas st
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine E. Taylor

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Richard J.Taylor Sr.

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Aug.4,1883

8. AGE: Years 63 | Months 6 | Days 7 | If less than one day ######## hr. ____ min.

9. Birthplace Baltimore,Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John G.May
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Richard J.Taylor Jr.
(b) Address 1810 N.Bond Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair rd.Balto:Md.

18 (a) Funeral director George J.Ruth,Inc.
(b) Address 1735 Harford Avenue

FEB 14 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/11 1947, at 3 15 P. M

21. I certify that I took charge of the remains described above, held an Autopsy & Insp thereon and from the evidence obtained by Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation from

Due to Illuminating Gas.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Feb. 11th 1947 2? P. M. 8/5
(b) Where did injury occur? 1803 N. Dallas st
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Burner on Kitchen range open, valve

23. Signature Howard J. Meeks M.D.
Medical Examiner.
Date signed 2/12/47

VS 151

PRESS WRITE FIRMLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G13600

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 55E

G15500 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1413 E Lafayette Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 341 E 21st St
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Catherine Schreiber

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:

4. Sex: Fmal
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Jerome Schreiber
6 (c) If alive, give age: 42 years
7. Birth date of deceased (mo., day, yr.): Sept. 10, 1910
8. AGE: Years 36 | Months 5 | Days 1 | If less than one day: ##### hr. min.
9. Birthplace: Baltimore, Md (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

MOTHER / FATHER
12. Name: Nicholas Meyers
13. Birthplace: Baltimore, Md.
14. Maiden Name:
15. Birthplace:

16 (a) Informant: Jerome J. Schreiber (Husband)
(b) Address: 1413 E. Lafayette Avenue
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair rd. Balto: Md.
18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue
19 (a) (b)
(Date rec'd by registrar) FEB 14 1947 Registrar, Huntington Hill

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 11 1947, at 3:45 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from June 1943, to Feb. 11 1947 and that I last saw her alive on Feb. 10 1947

| Immediate cause of death | Duration |
|---|---|
| Metastatic Sarcoma of lungs. | 15 mos. |
| Due to Sarcoma axillary glands | 4 years. |
| Due to Pigmented mole on right fore-arm. | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 1943 or axillary glands
Major findings of operation:
of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
73. Signature Bailey K. Ragon M. D.
Address 38 12 Greenmount Ave Date signed Feb. 11 47

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48601

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13a

Registered No. G48601

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5805 Halwyn Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Terry

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Charles D. Terry

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) May 24, 1874

8. AGE: Years 72 | Months 8 | Days 18 | If less than one day ####### hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Daniel Lane
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth Ring
15. Birthplace Ireland

16 (a) Informant Bernard E. Terry Sr.
(b) Address 3400 Virginia Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/14/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) (Date rec'd by registrar) (b) Huntington Ave

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/12/47 19 ; at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/18/ 1946 to 2/12/ 1947 and that I last saw her alive on 2/11/ 1947.

Immediate cause of death: Hypertensive cardio vascular renal disease. — Duration: one to two years.
Due to
Due to
Other Conditions none
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Deitel M. D.
Address 1226 Hanover St. Date signed 2/12/ 1947.

V S 190

FEB 14 1947

C18602

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1316

Registered No. C18602

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1748 Llewelyn Ave
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1748 Llewellyn Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Ida B. Foote

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F. | C | Widowed |

6 (b) Name of husband or wife Isaac Foote

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15th 1869

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 9 | 27 | hr. min. |

9. Birthplace Westmoreland Co. Va.
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name Robert Betts.
13. Birthplace Va

MOTHER 14. Maiden Name Sarah Edmonds
15. Birthplace Va.

16 (a) Informant Emma Keeton
(b) Address 1748 Llewelyn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-12-1947 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md.

18 (a) Funeral director Bascom Thomas & Haught
(b) Address 711 Gilmor St

19 (a) FEB 14 1947 (b) [illegible] Baltimore, Md.
(Filed, recorded by registrar)

V3 153

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12 1947, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Feb 12 1947 and that I last saw h.. alive on 2-10 1947

Immediate cause of death Chronic Myocarditis — Duration 2 years

Due to Congestive heart failure — 3 years

Due to

Other Conditions Chr. Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Calvin B. LeCompte M. D.
Address 1113 N Caroline St Date signed 2/13/47

93D

Reuben J. Polyanski

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 94a

C18603 — Registered No. C18603

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution: St Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 day
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Anne Arundel
(c) City or town Crownsville P.O.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Reuben J. Polyanski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 2 - 1888

8. AGE: Years 59 | Months 3 | Days 11 | If less than one day ..... hr. ..... min.

9. Birthplace Texas.
(Town, county, and state)

10. Usual Occupation Contractor.

11. Industry or business

FATHER 12. Name Michal J Polyanski

13. Birthplace Poland

MOTHER 14. Maiden Name Josephine Kuyawa

15. Birthplace Poland

16 (a) Informant Bertha Polyanski

(b) Address Crownsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-15-47 (month) (day) (year)

(c) Cemetery or crematory Our Lady of the Fields

Location Millersville, Md

18 (a) Funeral director L. L. Hopkins & Bro

(b) Address Annapolis Md

19 (a) FEB 14 1947 (Date received by local registrar) (b) Huntington Williams M.D. Registrar

VS 190

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 13 1947, at 3 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/12 1947 to 2/13 1947 and that I last saw h.e. alive on 2/13 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardiac Respiratory Failure | |
| Due to Coronary occlusion | |
| Due to Cent Arterial Embolus Rt Femoral. | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation 2/12/47.

Major findings of operation: Embolus Rt Femoral artery.

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur J. Owen M. D.

Address St Josephs Hosp. Date signed 2/13/47

X

G48604

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ X 20

Registered No. G48604

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. Physicians; please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Broadway and Fairmount Ave
(c) Hospital or institution:
The Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 122 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 122 days.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Anne Arundel
(c) City or town Eastport,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 6th Street.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Rawn, Reverend Archibald (Fairmount Heights)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M. |

6 (b) Name of ~~husband~~ wife Anna B. C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7 Nov 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 (59) | 3 | 7 | hr. min. |

9. Birthplace New Jersey (Town, county, and state)
10. Usual Occupation Minister.
11. Industry or business Pastor of Church.

FATHER
12. Name George R. Rawn
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Emma Belston
15. Birthplace Pennsylvania

16 (a) Informant Sister
(b) Address 511 6th Street, Eastport Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-47 (month) (day) (year)
(c) Cemetery or crematory Rock Hall.
Location Rock Hall, Md

18 (a) Funeral director John M. Taylor
(b) Address Annapolis Md.

FEB 15 1947 (Date rec'd by registrar)

Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 14 February 1947, at 11 A M

21. I certify that death occurred on the date above stated: that I attended deceased from 15 Oct 1946 to 14 Feb 1947, and that I last saw h.im alive on 14 Feb 1947.

Immediate cause of death Pneumonia
Failure and Edema
Coronary Thrombosis
Due to Arteriosclerosis moderate

Due to

Other Conditions Tuberculosis Kidney
Infarction Bladder Ulceration.
(Include pregnancy within 3 months of death)

Date of operation 10/21/46, 11/13/46, 12/3/46

Major findings of operation: Infarction Bladder
Extensive ulceration

of autopsy: 14 Feb 1947

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nicholas J. Kohlerman
Address Church Home & Hosp. Date signed M 14 D Feb 47

X

G48605

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 186a

(Registration No.) G48605

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd Street Guilford Ave 18
(c) Hospital or institution: Union Memorial Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5th da.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balt.
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2121 Guilford Ave. City 18
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** DANIEL Joseph Sommer

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-8558

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | |

6 (b) Name of husband or wife 0

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 8 | 2 | hr. min. |

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER — 12. Name Frederick M Sommer.
13. Birthplace Maryland

MOTHER — 14. Maiden Name Martha E Martin
15. Birthplace Md.

16 (a) Informant Martha E. Watson
(b) Address 2121 Guilford Ave

17 (a) Burial (b) Date thereof 2/17/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) Feb 15 1947 (b) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 13 1947, at 9 00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1947 to Feb 13 1947, and that I last saw h.. alive on Feb 13 1947.

| | Duration |
|---|---|
| Immediate cause of death: Uremia Respiratory failure | |
| Due to Paralysis below 6th Cervical region | 1½ mos. |
| Due to Cervical ruptured d.v. acute, traumatic C6 | 1½ Mos. |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 21 Dec 1946
Major findings of operation: Ruptured Disc Cervical, 6th
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 12/4
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 21 Dec 1946 at 2:00 P.M.
(c) Where did injury occur? Balt (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? —
(e) Means of injury Fell from stairs

23. Signature Howard J. Mallis, M.D.
Address Union Memorial Hosp. Date signed 2/14/47

VS 150

G48606

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

A 186a

G48606
Registered No.

Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 min
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Mass. (b) County
(c) City or town Boston
(If outside city or town limits, write RURAL and give town)
(d) Street No. 288 Shawmut Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Duncan Mac Dougall

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 45 | | | hr. min. |

9. Birthplace Mass
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name (Unknown) MacDougall
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Edward Hillman
(b) Address Munsey Building

17 (a) Burial (b) Date thereof 2/15/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto
Location Md.

18 (a) Funeral director Williams Cook Inc.
(b) Address 1202 St. Paul St.

19 FEB 15 1947 Courtesy for Williams
(Date rec'd by registrar)

FEB 15 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 1/26/1947, at 8 05 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shock from fractured pelvis, fractured ribs, ruptured kidneys, and intra-abdominal hemorrhage

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/26/47 ? 1/1 M.
(b) Where did injury occur? Pier #10 - Canton
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fell on pavement from truck

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 1/27/47

X

G48607

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G48607

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Fayette and Calhoun Sts.
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Howard
(c) City or town Marriottsville RURAL (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Alfred A. AMOS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, (married), widowed, or divorced.

6 (b) Name of husband or wife Ida M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 14 Dec 1872

8. AGE: Years 74 | Months 2 | Days 0 | If less than one day hr. min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business Farming.

FATHER
12. Name Oliver AMOS
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma MARR
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2- 12-47 (month) (day) (year)
(c) Cemetery or crematory Mt. View Cem.
Location Howard Co., Md.

18 (a) Funeral director C. Geary Weer
(b) Address Lynchburg, Md.

19 FEB 15 1947 (Date rec'd by registrar) Huntington Williams, Registrar

FEB 15 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 14 Feb 1947, at 11 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 Feb 47 19 to 14 Feb 1947, and that I last saw him alive on 14 Feb 1947

| | Duration |
|---|---|
| Immediate cause of death acute circulatory collapse, post operative | 1 Hour |
| Due to | |
| Due to | |
| Other Conditions acute and chronic gangrene of L. leg. (Include pregnancy within 3 months of death) | 3 years |

Date of operation 12 Feb 47 Debridement of L. leg: Acute and chronic gangrene of L. leg.
Major findings of operation:
of autopsy: Recent surgical operation of left leg. Debridement

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley B. Klyanovsky, M.D.
Address Frankford Sq. Hosp. Date signed 2/13/47

G48608

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

Registered No. G48608

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 834 Gough St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SOPHIA. RYDLEWSKI RYDZEWSKI

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Alexander

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 54 | Months - | Days - | If less than one day ... hr. ... min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business at Home

FATHER 12. Name A Dada

13. Birthplace Poland

MOTHER 14. Maiden Name Nosk

15. Birthplace Poland

16 (a) Informant Francis Arnault

(b) Address 26 S Covington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 17 1947 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Baltimore

18 (a) Funeral director Fred W Ozgowski

(b) Address 1930 Eastern Ave

19 (a) FEB 15 1947 (b) (Date received by Registrar) Washington Williams Mgr

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2-14-47 19... at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-10-1947 to 2-14-1947 and that I last saw h[illegible] alive on 2-13-1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Haemorrhage | |
| Due to Arteriosclerosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry T. Wilson, Jr M. D.

Address St. Joseph's Hosp Date signed 14 Feb 47

VS 150

C48609

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. C48609

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful correct age is especially important. Physicians: please write t

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2132 Arnold Hall ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2132 Arnold Hill ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Maria Barnes.

3 (b) If veteran, name war —
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F 67 | Col. | W. |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 7 | 3 | hr. min. |

9. Birthplace Harford Co. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Josiah Hall
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Charlotte Brown
15. Birthplace Md.

16 (a) Informant William Barnes
(b) Address 5514 Baker St.

17 (a) Burial (b) Date thereof 2-16-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory West Liberty Cem.
Location West Liberty, Howard Co. Md.

18 (a) Funeral director Mr. Francis A. Handley
(b) Address 548 W. Biddle St.

19 (a) FEB 15 1947 (Date rec'd by registrar) (b) [illegible] for Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-13-1947 at 10:32 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-24 1947 to 2-13- 1947, and that I last saw h[illegible] alive on 2-13- 1947

| Immediate cause of death | Duration |
|---|---|
| Cardio-Renal-Vascular Disease | 2 Mos. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George C. Riggs
Address 1816 Mount Ave. Date signed 2-14-47

VS 150

G48610

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G48610

CMK-107930

146M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1829 Druid Hill Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Wesley Cook

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Married |

6 (b) Name of husband or wife Frances
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9-1869

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 11 | 3 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Samuel Cook
13. Birthplace Maryland

MOTHER
14. Maiden Name Harriett Williams
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-47 (month) (day) (year)
(c) Cemetery or Crematory Arbutus Mem. Park
Location Baltimore Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 5718 W. Baddle St.

19 (a) (Date rec'd by Registrar) (b)

FEB 13 1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 12 19 47 at 12:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 25 19 47 to Feb. 12 19 47 and that I last saw him alive on Feb. 12 19 47

Immediate cause of death Arteriosclerotic Heart Disease — Duration

Due to

Due to

Other Conditions Ventral Hernia, Hyde. Cancinomas?
(Include pregnancy within 3 months of death)

Date of operation Jan. 29, 1947

Major findings of operation: Ventral Hernia

of autopsy: Not done.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice M. Lacy, M. D.
M. D.
Address Baltimore City Hosps. Date signed Feb. 12, 1947

X

G48611

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered G48611

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 520 N. Fremont Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 520 N. Fremont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** JAMES JOHN L. RICE

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-0066

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Married |

6 (b) Name of husband or wife Henrietta Rice.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 3 | 21 | hr. min. |

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Thomas Rice
13. Birthplace Va.

MOTHER
14. Maiden Name Indiana Maddox
15. Birthplace Va.

16 (a) Informant Mrs. Henrietta Rice
(b) Address 520 N. Fremont Ave.

17 (a) Burial (b) Date thereof 2-16-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 528 W. Fiddle St.

19 (a) FEB 15 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH Feb. 12, 1947, at 6:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 8 1946 to Feb 12 1947, and that I last saw h[illegible] alive on Feb 12 1947

| Immediate cause of death | Duration |
|---|---|
| (a) Cerebral Hemorrhage | 4 hrs |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Watts, M.D.
Address 515 Linden Ave. Date signed 2/13/47

VS 150

1947

X

G48612

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G48612

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1414 Clarkson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 Clarkson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lena M. Baker

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | W |

6 (b) Name of husband or wife Edward T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/3/1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 7 | 9 | hr. min. |

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Jacob Krause
13. Birthplace Ger.

MOTHER
14. Maiden Name Christina ?
15. Birthplace Ger.

16 (a) Informant Family
(b) Address 1414 Clarkson St.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 2/15/47 (month) (day) (year)
(c) Cemetery or crematory Eastern Cem.
Location Edmondson Ave.

18 (a) Funeral director James L. McCully
(b) Address 530 E. Fort Ave.

19 (a) FEB 15 1947 (Date rec'd by registrar) (b) Registrar

VS 180

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 12 1947 at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1947 to Feb 12 1947; and that I last saw h[illegible] alive on Feb 11 1947.

| Immediate cause of death | Duration |
|---|---|
| Myocardial Insufficiency | |
| Due to | |
| Due to | |
| Other Conditions Cystitis & Edema. Hypostatic. Bronchopneumonia | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Formerly PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Schwenck M. D.
Address 1337 S. Charles St. Date signed 2/14/47

G48613

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 163F

Registered No. G48613

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 Carswell Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Colvard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 58 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Pitts Co. Va (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business Cabinet Shop.

FATHER
12. Name D K
13. Birthplace " "

MOTHER
14. Maiden Name D K
15. Birthplace "

16 (a) Informant Virginia Colvard
(b) Address Danville Va

17 (a) ____ (Burial, cremation, or removal) (b) Date thereof Feb-16-47 (month) (day) (year)
(c) Cemetery or crematory Mt Hermon
Location Dompleville Va

18 (a) Funeral director Swicegood Funeral Home Sheppard & Etheridge
(b) Address Danville Va

19 Filed FEB 15 1947 Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12 1947, at 8 10 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH carbolic acid poisoning (phenol)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-12-47 ? M.
(b) Where did injury occur? 1611 Carswell St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Ingestion of carbolic acid

23. Signature Howard J. Waldeis M.D.
Medical Examiner.
Date signed 2/13/47

X

G48614

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1/13

Registered No. G48614

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 437 Parrish st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William CLAYTON CUFF

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: M
6 (b) Name of husband or wife: Beatrice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 31, 1899

8. AGE: Years 47 44 | Months 5 | Days 13 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Pearcey Cuff
13. Birthplace Md

MOTHER
14. Maiden Name Elizbeth Johnson
15. Birthplace Md

16 (a) Informant Beatrice Cuff
(b) Address 1928 Penna Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Chas. L. Nelson
(b) Address 1303 Presstman St

FEB 15 1941 (Date rec'd by registrar) (b) Baltimore, Md. Registrar

VS 191

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13, 1947, at 3 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Generalized miliary tuberculosis
Tuberculous peritonitis
Due to: Pulmonary tuberculosis
Emaciation

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 2/14/47

X

G48615 SULLENS

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

Registered No. G48615

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland Saratoga St.
(b) Street address Calvert & ~~Fayette~~
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25d.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Balto County (If outside city or town limits, write RURAL and give town)
(d) Street No. 7008 Willowdale Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anna M. Sullens

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife: John Sullens
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) July 26, 1909

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 37 38 | 6 8 | 16 19 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER — 12. Name Nicholas Blasch
13. Birthplace ~~Poland~~ Poland

MOTHER — 14. Maiden Name Voknows
15. Birthplace Poland

16 (a) Informant ~~Self~~ John Sullens
(b) Address 7008 Willowdale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Redeemer
Location Belair Rd.

18 (a) Funeral director M. W. E. Dippel's Sons
(b) Address Gay & East & Ann Sts.

FEB 15 1947 (Date rec'd by registrar)
(b) Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 1947, at 1:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 20 1947 to Feb 14 1947 and that I last saw her alive on Feb. 14 1947

| | Duration |
|---|---|
| Immediate cause of death Resp. Fail. | 2 hrs. |
| Due to Carcinomatosis | 3 mos. |
| Due to Carcinoma of Breast. | ? |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation Sept. 1943
Major findings of operations: Carc. of Breast.
of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William D. Gantz Jr. M. D.
Address Mercy Hosp Date signed 2-19-47

VS 150

X

G48616

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G48616 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4412 Parkmont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 4
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4412 Parkmont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Arthur Rooney McKenzie

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 222-09-4947

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Irene

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | | 21 | hr. min. |

9. Birthplace Cleveland, Ohio (Town, county, and state)

10. Usual Occupation Asst Salesman

11. Industry or business Standard Oil Co.

FATHER
12. Name John McKenzie
13. Birthplace Scotland

MOTHER
14. Maiden Name ~~John McK~~ Mary Rooney
15. Birthplace Scotland

16 (a) Informant Irene McKenzie
(b) Address 4412 Parkmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 / 15 / 47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Erdman Ave. Baltimore Md

18 (a) Funeral director W. W. E. Dugoli's Sons
(b) Address Lombard & Fulton Sts.

FEB 15 1947 (Date received by local registrar) Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2-13-1947, at 12 noon M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/28 1945, to 2-13-1947 and that I last saw him alive on 2-12-1947.

| Immediate cause of death | Duration |
|---|---|
| Acute coronary insufficiency | |
| Due to Coronary Sclerosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Hornsleen M. D.

Address 723 Augusta St Date signed 2/14/47

X

G48617 CWK-108055

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 47a

Registered No. G48617

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 47 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 115 E. Franklin Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Felix Prybyl.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30-1898

8. AGE: Years 48 | Months 8 | Days 6 7 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Val Prybyl

13. Birthplace Poland

MOTHER 14. Maiden Name Rose Rose Jaskulski

15. Birthplace Poland

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 2 / 15 / 47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Sacred Heart Cemetery
Location Baltimore Co. Md.

18 (a) Funeral director H. W. Meiserlow

(b) Address 805 N. Calvert St.

19 (Signature) Huntington Williams M.D.
(Registrar)

FEB 17 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 6 1947, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 30 1947 to Feb. 6 1947, and that I last saw h. alive on Feb. 6 1947.

Immediate cause of death: Carcinoma of Larynx — Duration: 1 yr.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice M. Lacy M. D.

Address Baltimore City Hosp. Date signed 2-15-47

VS 150

X

48618

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 467

G48618 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written; write the causes of death clearly and legibly. Physicians: please write in full. Street age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2621 Hudson St.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2621 Hudson St. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** Susan Wojcik

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widowed |

6 (b) Name of husband or wife Thomas Wojcik
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14 1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 7 | 29 | hr. min. |

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant James Wojcik
(b) Address 2621 Hudson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/47 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cem.
Location Dundalk Md

18 (a) Funeral director John F. Duda
(b) Address 2869 Hudson St

19 (a) FEB 15 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 8

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 13 1947, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1946 to Feb 13 1947, and that I last saw h. alive on Feb 13 1947

| Immediate cause of death | Duration |
|---|---|
| Diabetes Mellitus | 1-2-46 |
| Due to Carcinoma of Rectum | |
| Due to | |
| Other Conditions None | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eric Schmancek M. D.
Address 421 E. 33rd St Date signed 2-14-47

G48619

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 108

Registered No. G48619

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2075 N. Fayette Street
(c) Hospital or institution: Bon Secours

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 29 years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5702 Falls Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** (Mrs. Ella Rapka) Elmira Jane Rapka

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| — | — |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife: Albert F. Rapka
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Aug 12-1858

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 88 | 6 | 2 | hr. min. |

9. Birthplace Baltimore Co. Maryland
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

**FATHER**
12. Name Jacob Baughman
13. Birthplace Pennsylvania

**MOTHER**
14. Maiden Name Mary Ashurst
15. Birthplace England

16 (a) Informant Mrs Celia E. Combes
(b) Address 5702 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 16-1947 (month) (day) (year)
(c) Cemetery or crematory Poplar
Location Warren, Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 FEB 15 1947 Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 14 1947, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1947 to Feb 14 1947 and that I last saw her alive on Feb 13 1947

| Immediate cause of death | Duration |
|---|---|
| Cardiac Failure | 5 days |
| Due to Coronary Thrombosis | 5 days |
| Due to | |
| Other Conditions Pneumonia, RUL | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E. Farber M. D.
Address Bon Secours Hosp., Balt. Date signed 2-17-47

VS 160

94a

G48620

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 108

Registered No. G48620

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Central Hotel
419 W. Lafayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Simon Stolow

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-5-98

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 48 49 | 11 | 9 | hr. min. |

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Mercantile
11. Industry or business

FATHER
12. Name Joseph Stolow
13. Birthplace Russia

MOTHER
14. Maiden Name Shina Levick
15. Birthplace Russia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-15-47 (month) (day) (year)
(c) Cemetery or crematory Brooklyn
Location New York
18 (a) Funeral director Jack Levin
(b) Address 1439 E. Baltimore St

FEB 15 1947
Baltimore, Md.
FEB 15 1947

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb 14 1947 at 5:00 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Feb 13 1947 to Feb 14 1947 and that I last saw him alive on Feb 14 1947

| Immediate cause of death | Duration |
|---|---|
| PNEUMONIA, LEFT LOWER LOBE | 3 DAYS |
| Due to PNEUMOCOCCUS, TYPE 24 | |
| Due to | |
| Other Conditions ACUTE LEFT HEART FAILURE | HOURS |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maxwell Williams M. D.
Address Johns Hopkins Hospital Date signed 2-15-47

G48621

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

49a

Registered No. G48621

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Fla (b) County Volusia
(c) City or town Daytona Beach
(If outside city or town limits, write RURAL and give town)
(d) Street No. 236 N. Halifax Ave (If rural give location) Fla
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Miriam Jaya Eisgrau

3 (b) If veteran, name war

3 (c) Social Security Account No. 264-22-7268

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George J.

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 10-25-05

8. AGE: Years 41 | Months 4 | Days 9 | If less than one day: hr. min.

9. Birthplace (City) England (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jack Jaya
13. Birthplace England

MOTHER
14. Maiden Name Fannie Millar
15. Birthplace England

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-15-47 (month) (day) (year)
(c) Cemetery or crematory Hartford Conn.
Location Jack Lewis Inc

18 (a) Funeral director
(b) Address 1439 E. Baltimore St

(Date received by registrar) FEB 15 1947 (b) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 14 1947 at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1947 to Feb 14 1947 and that I last saw h[illegible] alive on Feb 14 1947

Immediate cause of death Adenocarcinoma grade three metastatic to omentum, cachexia — Duration: Nine Months

Due to

Due to

Other Conditions anemia, secondary

(Include pregnancy within 3 months of death)

Date of operation 2-7-47

Major findings of operation: carcinomatosis abdomen

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Edward L. Suarez-Murias M.D.

Address Johns Hopkins Hospital Date signed Feb 15 1947

G48622

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G48622

G48622 Dec 107727

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 45- 3- 4-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2817 Denham Circle-Cherry Hill
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Irene Richardson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Colored | Widowed |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 8-1901

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 45 | 3 | 4 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Richard Tongue (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Oliva ?
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 15, 1947 (month) (day) (year)
(c) Cemetery or crematory Sardis Memorial
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Johnson St Huntington Indiana

19 (a) FEB 15 1947 (b) (Registrar) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 12 19 47 at 4:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 18 19 47 to Feb. 12 19 47, and that I last saw her alive on Feb. 12 19 47.

| Immediate cause of death | Duration |
|---|---|
| Syphilitic Menings Encephalitis | 1 mo. |
| Due to Syphilis Generalized | — |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edmund Beerman M.D.
Address Balto City Hosp Date signed 2-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age if especially important.

G48623

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G48623

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3604 Glengyle Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3604 Glengyle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** SADIE FISHER

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1859

8. AGE: Years 87 | Months 5 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none
11. Industry or business

FATHER 12. Name Daniel Fisher
13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Roop
15. Birthplace Germany

16 (a) Informant Mrs. Louise I. Mitchell
(b) Address 3604 Glengyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/47 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 15 1947 (Date rec'd by registrar) (b)

Entered for Public Record

V S 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 14, 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1946 to Feb 14 1947, and that I last saw h[illegible] alive on Feb 13 1947

| | Duration |
|---|---|
| Immediate cause of death: Coronary Thrombosis | 24 hrs |
| Due to: General Arteriosclerosis Confluae Atheroma | yrs |
| Due to: Senility | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James E. Ashenhurst M. D.
Address 4 Park Heights Av Date signed 2-15-47

G48624 BC# G68491

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1613

G48624 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Rayner & Hartsdale
(c) Hospital or institution Mer. Baltimore 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2651 W. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sharon Marie Milleker (Milleker)

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: no

4. Sex: Fmale
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife -- JAUARY 18, 1947
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days 25 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Milleker
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Irma Ritz
15. Birthplace Balto., Md.

16 (a) Informant Mr. Joseph Milleker
(b) Address 2651 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/15/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto. Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 15 1947 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 13 1947, at 5 45 P. M

21. I certify that death occurred on the date above stated: that I attended deceased from Oct 1947 to 13 Feb 1947, and that I last saw h[illegible] alive on 13 Feb 1947.

| Immediate cause of death | Duration |
|---|---|
| Sepsis | |
| Due to Pertonitis | |
| Due to Pneumonia Bilateral | |
| Due to Frostbite. | |
| Other Conditions Hypo to Cellulas Tis. | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lester A. Shaeffer M.D.
Address West Baltimore Hosp. Date signed 2/13/47

VS 150

G48625

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

95c

Registered No. G48625

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 3 (4) days
(e) Length of stay in Baltimore (yrs., mos., or days): 4 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 1702 Lancaster St.
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country: Cape Verde Islands

3 (a) FULL NAME: De Mendonca, Alberto Coelho

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: M

5. Color or race: Portuguese

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 13, 1924

8. AGE: Years: 23 | Months: 0 | Days: 28 | If less than one day: hr. min.

9. Birthplace: Guiana (Town, county, and state)

10. Usual Occupation: fireman & watertender

11. Industry or business: Seafarer

FATHER
12. Name: Nicholas De Mendonca
13. Birthplace: Caville Island

MOTHER
14. Maiden Name: Antonia ?
15. Birthplace: Caville Island

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-47 (month) (day) (year)
(c) Cemetery or crematory: St. Matthews
Location: O'Donnell St.

18 (a) Funeral director: Lilly & Zeiler Inc.
(b) Address: 403 S. Bond St.

Date received by Registrar: FEB 15 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Feb. 10 1947, at 8:50A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7 1947 to Feb. 10 1947 and that I last saw him alive on Feb. 10 1947.

Immediate cause of death: Nephritis sub-acute — Duration: Few MONTHS

Due to:

Other conditions: Cardiac hypertrophy — UNKNOWN

Due to:

Other Conditions: Bronchial pneumonia — 1 wk.

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed: 2/14/47

VS 150

X

G48626

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

161c

Registered No. G48626

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure that correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto Gen. Hosp-
(d) Length of stay in hospital or inst. (yrs., mos., or days) hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) ~~County~~ Howard
(c) City or town Jessups (If outside city or town limits write RURAL and give town)
(d) Street No. 3046 9 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Baby Girl Quinn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 13 - 1947

8. AGE: Years | Months | Days | If less than one day: 15 hrs min.

9. Birthplace Baltimore Md - (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John M Quinn
13. Birthplace Balto Md -

MOTHER 14. Maiden Name Catherine Johnson
15. Birthplace Baltimore Md

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-47 (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral
Location Edmondson Ave.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 1007 S. Wolfe St.

FEB 15 1947 (Date rec'd by registrar)

Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 13 1947 at 11 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-13 1947, to 2-13 1947 and that I last saw her alive on 2-13 1947

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure | |
| Due to Hemorrhage into adrenal | |
| Due to | |
| Other Conditions Congenital Hemolytic disease of newborn (Include pregnancy within 3 months of death) | |

Date of operation

Major findings of operation: Hemorrhage into adrenal Enlarged liver

Autopsy? Yes

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. J. Tregtau M. D.
Address W. Balto Gen. Hosp Date signed 2-14

VS 150

G18627 ANSTINE

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1310

Registered No. G48627

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1836 E
(c) Hospital or institution: Dom Sweet Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1836 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Clarence Leroy Anstine

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Augusta P.
6 (c) If alive, give age: 51 years
7. Birth date of deceased (mo., day, yr.): May 11-1897

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 49 | 9 | 1 | hr. min. |

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Druggist
11. Industry or business

FATHER
12. Name: Chester C. Anstine
13. Birthplace: Pa

MOTHER
14. Maiden Name: Unknown
15. Birthplace:

16 (a) Informant: Augusta P. Anstine
(b) Address: 1836

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec 17-47 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cem.
Location: Baltimore, Md.

18 (a) Funeral director: Frazier & Kenny
(b) Address: Harlem & Gilmor

19 (c) FEB 15 1947 Washington Williamsport, Md.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/12 1947, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1946, to 2/12 1947, and that I last saw h[illegible] alive on 2/12 1947.

| Immediate cause of death | Duration |
|---|---|
| Arteriosclerotic Gidet. Vascular Renal Disease | 3 |
| Due to | |
| Due to | |
| Other Conditions Obesity | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: H Clarence Langfelder
Address: 401 N. Payson St. Date signed: 2/15/47 M. D.

VS 2

648628

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. 648628

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yr

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3404 Devonshire Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISREEL LAZARUS

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| — | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife Bertha
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Park Ave & Hamilton Ave

18 (a) Funeral director Jewish Sons
(b) Address 1439 E. Balto St

FEB 15 1947 (a) (Registrar) (b) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 14 1947, at 11 55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 14 1947 to Feb 14 1947, and that I last saw h alive on Feb 14 1947.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary edema | |
| Due to Coronary insufficiency | |
| Due to Arteriosclerosis and hypertensive cardiovascular disease | |
| Other Conditions Azotemia | |

Operation, cancer or accident
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Heinz Blessing M.D.
Address Sinai Hospital Date signed Feb 14 1947

X

G48629
CWK-82640

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 94a

G48629

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3- 6- 29-
(e) Length of stay in Baltimore (yrs., mos., or days) 43xYears

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 608 E. Baltimore Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Crowley

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12-1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 7 | 2 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Crowley
13. Birthplace Ireland

MOTHER
14. Maiden Name Katherine Fatheny
15. Birthplace Ireland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director P.C. Higinbotham
(b) Address 647 East Pratt Street Md.

FEB 16 1947 (b)
(Date rec'd by registrar) Registrar

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** February 14 1947, at 10:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1943, to Feb. 14 1947, and that I last saw him alive on Feb. 14 1947.

| | Duration |
|---|---|
| Immediate cause of death Pulmonary embolism | 3 days |
| Due to Myocardial Infarction | 2 weeks |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature C. R. Huntington Williams, M.D.
Address Baltimore City Hosp. Date signed 16 Feb 47

Huntington Williams, M.D.

G48630

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1314

G48630
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3514 Fleet Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3514 Fleet Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Gunya

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Gunaya

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1879

8. AGE: Years 67 | Months 24 | Days 18 | If less than one day ____hr. ____min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retaria

11. Industry or business

FATHER
12. Name Joseph Gatter
13. Birthplace Unknown

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Unknown

16 (a) Informant Mary Jaeger (Friend)
(b) Address 3514 Fleet Street

17 (a) BURIAL (b) Date thereof 2-17-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Mem.
Location 4430 Belair Rd.

18 (a) Funeral director Charles S. Geiler
(b) Address 4495 Fait Ave.

FEB 18 1947

19 (a) (Date rec'd by registrar) (b) Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 1947, at 10:15 AM

21. I certify that I took charge of the remains described above, held an Autopsy & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cardiovascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Teagarden M.D.
Medical Examiner.
Date signed 2-18-47

VS 191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48631

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G48631
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: 15 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2036 Ruxton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** RUBIN MAGAZINER

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-3836

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Lena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2/1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | | 13 | hr. min. |

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation
11. Industry or business Baker

FATHER
12. Name Gilbert Magaziner
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Harry A. Magaziner
(b) Address 5029 Pembridge Ave.

17 (a) Burial (b) Date thereof Feb 16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Workmen's Circle Cemet.
Location Mt. Carmel Rd.

18 (a) Funeral director SOL LEVINSON & BROS.
(b) Address 1124-26 W. North Ave.

19 (a) (b)
(Date filed by registrar) Registrar

FEB 18 1947
VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15th 1947, at 7.25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 13th 1947 to Feb 15th 1947, and that I last saw him alive on Feb 15th 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary Tr. Occlusion | |
| Myocardial Infarction | |
| Due to Art. Sc. Hrt. Disease | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rosalyn Bauman Jr. M. D.
Address Sinai Hosp. Date signed 2/15/47

X

G48632

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48 B

G48632 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 417 N. Chester Street
(c) Hospital or institution: b

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 417 N. Chester Street
(If Rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Catherine Jane Bennett

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) March 17, 1887

8. AGE: Years 59 | Months 10 | Days 27 | If less than one day ########## min.

9. Birthplace ######## Baltimore, Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name William T. Bennett
13. Birthplace Snow Hill, Maryland

MOTHER
14. Maiden Name Catherine Marian
15 Birthplace Ireland

16 (a) Informant Ida E. Bennett
(b) Address 417 Chester Street

17 (a) Burial (b) Date thereof 2/17/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

FEB 6 1947 (b) ———
(Date rec'd by registrar) Registrar

V S 190

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/14/47 19 ... at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1946 to Feb 1947 and that I last saw h[illegible] alive on Feb 17 1947

| Immediate cause of death | Duration |
|---|---|
| CARCINOMA VIRGIS. | 2 YRS |
| Due to | |
| Due to | |
| Other Conditions UREMIA | 3 DAYS |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James F. Kavanagh M.D.
Address 3014 McElderry St Date signed 2-15-47 M. D.

X

G48633

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

Registered No. G48633

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert & Centre Sts
(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Baltimore 5 Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 609 N Luzerne Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Sophonia Webster

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-14-0470

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | widowed |

6 (b) Name of husband or wife: Edward Webster
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) June 18, 1863

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 7 | 27 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

| | |
|---|---|
| FATHER | 12. Name Hiram Tanhersalie |
| | 13. Birthplace Maryland |
| MOTHER | 14. Maiden Name Biddie Ann |
| | 15. Birthplace Maryland |

16 (a) Informant Edward L. Malstrom
(b) Address 609 N. Luzerne Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 2/17/47. (month) (day) (year)
(c) Cemetery or crematory Morelands Duke
Location Taylor Ave. Balto Co.

18 (a) Funeral director George J. Ruth Inc
(b) Address 735 Hartford Ave

FEB 16 1947 (Date rec'd by registrar) Huntington Nellis

VS 190

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1947, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 27 1947 to Feb 15 1947, and that I last saw her alive on Feb 15 1947.

Immediate cause of death: Cardiac failure — Duration

Due to: H.C.V.D.

Due to: Carcinoma Breast C. metastasis to Lungs Liver

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward L. Smith M.D. M. D.
Address Mercy Hospital Date signed 2-16-47

G48634 ✓ G48634

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1105 McDonogh Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 McDonogh Street
(If no No, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Louis B. Huber

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary A. Stenger
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) April 5th. 1868

8. AGE: Years 78 | Months 10 | Days 9 | If less than one day ###### min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business House painter

FATHER: 12. Name Michael Huber
13. Birthplace Germany

MOTHER: 14. Maiden Name ? Kelchenstein
15. Birthplace Germany

16 (a) Informant Mrs. Helen A. Wade
(b) Address 1105 McDonogh Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair rd.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) FEB 1 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

V S 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/14/47 1947, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 8 1947, to Feb. 14 1947 and that I last saw him alive on Feb. 14th 1947

| Immediate cause of death | Duration |
|---|---|
| CORONARY THROMBOSIS | |
| Due to ARTERIO SCLEROSIS | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry W. Rosenthal M. D.
Address 1902 Eutaw Place Date signed 2-15-47

X

G48635 — BALTIMORE CITY HEALTH DEPARTMENT — G48635

# CERTIFICATE OF DEATH

CWK-108364 — 108 — Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 55- 6- 26-

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 716 S. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Henry Link

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-14-5727

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widower |

6 (b) Name of husband or wife Marie (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17-1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | 6 | 26 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Marine Engineer
11. Industry or business

FATHER — 12. Name William (D)
13. Birthplace Maryland

MOTHER — 14. Maiden Name Mary Goss
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Gor Patapsco Highway

18 (a) Funeral director Milton Stabilberg
(b) Address 3914 Hanover St

19 (a) 1947 (Date rec'd by registrar) Thurlington Williams, M.D. Registrar

VS 150

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH February 13 1947, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 11 1947 to Feb. 13 1947 and that I last saw h. im alive on Feb. 13 1947.

| | Duration |
|---|---|
| Immediate cause of death: Lobular Pneumonia | ? hours |
| Due to: Chronic glaucoma | ? |
| Due to: Coronary thrombosis | ? |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Reynolds Hall M. D.
Address Baltimore City Hospitals Date signed 2/17/47

X

G48636

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

X ✓ G48635 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Parkville
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 Alden Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM KELLENBECK

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | M. |

6 (b) Name of husband or wife Jennie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 10 | 5 | hr. min. |

9. Birthplace Md. (Town, county, and State)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name Sarah ✓
15. Birthplace ✓

16 (a) Informant Mrs. Charles Flater
(b) Address 2803 Alden Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 530 S. Hanford Rd.

19 (a) [illegible] 194[illegible] (Signature of Registrar) Wilhelmina M.D. Registrar

FEB 16 194[illegible]

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/14 1947, at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/13 1947 to 2/14 1947 and that I last saw h[illegible] alive on 2/14 1947.

| Immediate cause of death | Duration |
|---|---|
| PERIPHERAL VASCULAR COLLAPSE | |
| Due to MYOCARDIAL INFARCTION | |
| Due to CORONARY THROMBOSIS | |
| Other Conditions HYPERTENSIVE CARDIOVASCULAR DISEASE (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert [illegible]
Address 3706 Rosedale Rd Date signed 2/17/47 M.D.

VS 150

Dr. Wilson
617 W. 40th St.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

G48637
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3511 Hickory Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3511 Hickory Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William H. Beasley, Sr.

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Sue Dorothy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 9 | 25 | hr. min. |

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Samuel Beasley
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Sue D. Beasley
(b) Address 3511 Hickory Avenue

17 (a) Burial (b) Date thereof 2/17/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore
18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road
19 (a) FEB 16 1947 (b)
(Date rec'd by registrar) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 14, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 27 1946, to Feb. 14 1947, and that I last saw him alive on Feb. 14 1947.

| Immediate cause of death | Duration |
|---|---|
| Myocardial Insuffiriency | 1 day |
| Due to Left Cerebral Hemorrhage | 13 days |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. N. Wilson M. D.
Address 617 W. 40th St. Date signed 2/15/47

Huntington for Williams MD

X

Dr G48638

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46E

G48638

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Please see that age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2602 Hermosa Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2602 Hermosa Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Elizabeth Keating

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widowed |

6 (b) Name of husband or wife: Joseph J. Keating
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 5, 1869

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 11 | 8 | hr. min. |

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual Occupation: at home
11. Industry or business

FATHER
12. Name: John Teipe
13. Birthplace: Md.

MOTHER
14. Maiden Name: Catherine ?
15. Birthplace: Md.

16 (a) Informant: Mrs. George J. Miller
(b) Address: 2602 Hermosa Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/47 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: Baltimore

18 (a) Funeral director: Leonard J. Ruck
(b) Address: 5305 Harford Road

6 1947

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

Huntington Williams, Md

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 13th, 1947 at 11:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-25 1946 to Feb 13 1947 and that I last saw h[er] alive on Feb 11 1947

Immediate cause of death: Carcinoma of Colon (Duration ?)
Carcinoma of liver
Metastasis to (Nodules)
Due to

Due to

Other Conditions: Chronic myocarditis
Uremia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: H. V. Harbold M. D.
Address 4706 Harford Road Date signed 2/14/47

X

G48639

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G48639 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd St.
(c) Hospital or institution:
UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County Harford 24
(c) City or town BALTIMORE Co.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 LEEDS TERRACE, BALTO.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MYRTLE GLEN CLARK.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | M. |

6 (b) Name of husband or wife FLOYD E. CLARK.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 29, 1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 11 | 18 | hr. min. |

9. Birthplace NEBRASKA.
(Town, county, and state)
10. Usual Occupation HOUSEWIFE.
11. Industry or business —

FATHER
12. Name JOHN GLEN.
13. Birthplace SCOTLAND.

MOTHER
14. Maiden Name HETTIE ?
15. Birthplace NEBRASKA.

16 (a) Informant FLOYD E. CLARK.
(b) Address 1216 LEEDS TERRACE, BALTO.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 17-1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director John R. Kenny
(b) Address 1202 Linden Ave. If delayer 21

19 (a) 194 (b) Date received by registrar Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** FEB. 15, 1947, at 8:15 A.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from FEB. 15, 1947, to FEB. 15, 1947, and that I last saw HER alive on FEB. 15 1947.

| Immediate cause of death | Duration |
|---|---|
| CEREBROVASCULAR ACCIDENT | 15 hrs. |
| Due to HYPERTENSIVE CARDIOVASCULAR DISEASE | 5 yrs. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Crawford W. Hollyfield, Jr. M. D.
Address Union Memorial Hosp. Date signed 2-15-47

G48640

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48640 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 67 Days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** Edward Curtaini

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | white | widowed |

6 (b) Name of husband or wife Bertha Hamilton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 25 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 3 | 20 | hr. min. |

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation watchman
11. Industry or business

FATHER 12. Name Wm Curtaini
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name ?
15. Birthplace

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 18/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St

Feb 16 1947 (Date filed by Registrar) Huntington Williams, M.D. Registrar

VS 3

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1947, at 9-45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1947, to Feb 14 1947, and that I last saw him alive on Feb 14 1947.

| Immediate cause of death | Duration |
|---|---|
| Edema Lungs | 2 days |
| Due to Cerebral Hemorrhage | 4 days |
| Due to | |
| Other Conditions Arteria-Sclerosis | 5 yrs |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E. North Av Date signed 2/15/47

X

G48641

BALTIMORE CITY HEALTH DEPARTMENT ✓ G48641

CERTIFICATE OF DEATH 937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St. City
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 85 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Henry Simmons

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1861

8. AGE: Years 85 | Months 2 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business

FATHER 12. Name Thomas Simmons

13. Birthplace

MOTHER 14. Maiden Name Dorothy Tuban

15. Birthplace

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 17, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St

19 (a) Huntington Williams M.D. Registrar
Date received by registrar FEB 19 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb-14- 1947, at 4-30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10- 1947, to Feb-14 1947, and that I last saw him alive on Feb 14- 1947.

| Immediate cause of death | Duration |
|---|---|
| Edema Lungs — | 3 days |
| Due to Chronic Myocarditis | 5 yrs |
| Due to | |
| Other Conditions Cerebro-Sclerosis | 10 yrs |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E North Av Date signed 2/15/47

X

G48642 DCH G49137

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 106c

G48642 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. This correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 8 months

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 Callon Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jon Bass

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1946

8. AGE: Years | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Infant

11. Industry or business

FATHER
12. Name Sylvan Bass
13. Birthplace Boston, Mass. Baltimore, Md.

MOTHER
14. Maiden Name Carol Beery
15. Birthplace Boston, Mass

16 (a) Informant Sylvan Bass, father
(b) Address 2109 Callon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville Md.

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

FEB 16 1947 (Date received by registrar) (b) Huntington Woods Station, Md.

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 14 1947, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from February 13 1947, to February 14 1947, and that I last saw h.i.M alive on February 14 1947.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Laryngo-Trachio-bronchitis | 2 days |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert J. Sheldon M. D.
Address Sydenham Hospital Date signed 2-14-47

G48643

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

✓ G48643 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2506 Hollins Street
(c) Hospital or institution: ✓ 40
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2506 Hollins St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph O. Stamm - Stamm

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. -

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Eleanor C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 4, 1880

8. AGE: Years 66 | Months 6 | Days 11 | If less than one day hr. min.

9. Birthplace Howard Co. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Balto Trust Co.

FATHER 12. Name Joseph Stamm

FATHER 13. Birthplace Germany.

MOTHER 14. Maiden Name Mary Hohn

MOTHER 15. Birthplace Germany

16 (a) Informant Mrs. Eleanor C. Stamm

(b) Address 2506 Hollins St -

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery

Location 4300 Old Frederick Road

18 (a) Funeral director John J. Lowe & Son

(b) Address 911-13 W. Hollins St -

(a) Date rec'd by registrar FEB 16 1947 (b) Buried by Huntington Williams Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/15/47 19 ..... at 1:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Dawson M.D.
Medical Examiner.
Date signed 2/15/47

X

Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48644 ✓ G48644

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1434 W. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael V. Cooney

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3rd 1891

8. AGE: Years 55 | Months 5 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Gentleman

FATHER 12. Name Michael Cooney.

13. Birthplace Indiana

MOTHER 14. Maiden Name Mary E. M. Gorgan

15. Birthplace Ind

16 (a) Informant Mrs Leo F. Cooney.

(b) Address 1434 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/7/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery

Location 4300 Edmondson Road

18 (a) Funeral director John F. Connolly

(b) Address 1003 W. Fayette St

19 (a) (Date) (by registrar) (b) Registrar

B 16,197

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/4/47 1947, at 12:05 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-Renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Trebumbo M.D.
Medical Examiner.

Date signed 2/4/47

X

G48645

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 47

G48645
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 507 Mosher St.
(c) Hospital or institution:
14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 507 Mosher St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stephen Langley

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-7414

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Col | Divorced |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 7 | | hr. min. |

9. Birthplace Greenville N. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Clarice Clark
15. Birthplace Greenville N.C.

16 (a) Informant Josephine Hall
(b) Address 565 W. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 16 47 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Wm. Katie R. Williams
(b) Address 326 N. Schroeder St.

19 (a) (b)
(Date rec'd by registrar) Registrar

1947
6 vs 155

## MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Feb. 1947 at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-31-1946 to 17 Feb. 1947, and that I last saw h alive on 14 Feb. 1947.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of Cervix | 6 mos. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James D. Carr M. D.
Address 515 Mosher St. Date signed 2-16-47

X

G48646

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G48646

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1515 W. Pratt St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 W. Pratt St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Catherine Frances Norwood.

3 (b) If married, name wife — None
3 (c) Social Security Account No. 215-24-4365

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Cornelius J. Norwood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 6, 1871

8. AGE: Years 76 | Months 1 | Days 6 | If less than one day: hr. min.

9. Birthplace Hartford County Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name ? Cain
13. Birthplace Maryland

MOTHER
14. Maiden Name Ellen Facey
15. Birthplace Maryland

16 (a) Informant Catherine Hazlove
(b) Address 4733 Amberley Ave.

17 (a) Burial (b) Date thereof 2-17-47
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director Geo. L. Schwab
(b) Address 2101 Frederick ave.

19 (a) Date received by local registrar FEB 17 1947 (b) Huntington Williams M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/17 1947 at 6.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1946 to 2/17 1947; and that I last saw her alive on 2/13 1947.

Duration

Immediate cause of death (CEREBRAL) HEMORRHAGE
Due to ARTERIOSCLEROTIC
C. V. D.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. C. Rund M. D.
Address 332 S. Frederick Ave. Date signed 2/17/47

G48647

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

R G48647

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 215 S. Monroe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 215 S. Monroe St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Annie McCabe

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: George McCabe
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) August 20, 1867

8. AGE: Years 79 | Months 6 | Days 25 | If less than one day: hr. min.

9. Birthplace St. Marys County, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Dorothy Engelhardt
(b) Address 1306 S. Ostow Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave.

FEB 17 1947 (b) [illegible] Huntington Williams, M.D.
(Date received by registrar)

VS 180

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 14, 1947 at 5:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1946 to Feb 14 1947.
and that I last saw h[illegible] alive on Feb 13 1947.

Immediate cause of death Pulmonary Edema. — Duration

Due to Cerebral Hemorrhage

Due to Hypertension — Arteriosclerosis

Other Conditions Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norbert C. Nitsch M. D.
Address 2157 Walbrook Ave. Date signed 2/15/47

C48648 JL - 9354

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Reg. No. C48648

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 - 3 - 3
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 Augusta Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles Root

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Agnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 0 | 11 | hr. min. |

9. Birthplace Thomas, W. Va.
(Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business

FATHER
12. Name David
13. Birthplace W. Va.

MOTHER
14. Maiden Name Margaret Close
15. Birthplace W. Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) 2-19-47 (Burial, cremation, or removal) (b) Date thereof Burial (month) (day) (year)
(c) Cemetery or crematory Dove Mac Run
Location West Va.
18 (a) Funeral director John C. Melly Inc
(b) Address 2432 E. Oliver St.
19 FEB 17 1947 (Date rec'd by registrar) Huntington, W. Va. Registrar

VS 150

**MEDICAL CERTIFICATION** PM

20. DATE OF DEATH Feb. 15 1947, at 11.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-12-32 19 to Feb. 15 1947, and that I last saw h im alive on Feb. 15 1947

| Immediate cause of death | Duration |
|---|---|
| Circulatory Failure | |
| Due to Arteriosclerotic Heart Disease | |
| Due to | |
| Other Conditions Chronic Rheumatoid Arthritis | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wm R Pearsall M. D.
Address Bureau City Hosp Date signed 2-16-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

648649

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 832

Registered No. 648649

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2211 Rogers Ave
(c) Hospital or institution: Methodist Home for Aged
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogers Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Dunbard Marshall

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced:

6 (b) Name of husband or wife: Leo Bella
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 8 | 15 | hr. min. |

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Inmate
11. Industry or business Home for Aged

FATHER
12. Name Robert Marshall
13. Birthplace Virginia

MOTHER
14. Maiden Name Virginia Spence
15. Birthplace Virginia

16 (a) Informant Mrs Virginia Savage
(b) Address 2211 W. Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St

FEB 17 1947 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-15 1947 at 1.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Feb 15 1947 and that I last saw h[illegible] alive on Feb 15 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 3 days |
| Due to Arteriosclerosis | 20 yrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Anthony J Davies M. D.
Address 700 N. Broadway Date signed 2-15-47

VS 150

G48650

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 95c

Registered No. G48650

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2426 Arunah Ave.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18yr 4mo

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2426 Arunah Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred Virginia Neal

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | |

6 (b) Name of husband or wife Frank Hall Neal
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct-29-1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 3 | 16 | hr. min. |

9. Birthplace Church Hill Md.
(Town, county, and state)
10. Usual Occupation Houses - work
11. Industry or business

FATHER
12. Name Francis Andrews
13. Birthplace Aberdeen Md.

MOTHER
14. Maiden Name Sarah Wilson
15. Birthplace Aberdeen Md.

16 (a) Informant Frank H Neal
(b) Address 2426 Arunah Ave.

17 (a) Burial (b) Date thereof 2/18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

FEB 17 1947
(Date rec'd by registrar)

(Signature of Registrar)

VS 250

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 14 1947, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 12-1946, to Feb 14-1947, and that I last saw her alive on Feb 13-1947.

| Immediate cause of death | Duration between onset and death |
|---|---|
| Organic Heart Disease | |
| Due to | |
| Due to | |
| Other Conditions Hypertension | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chester Rilandy M. D.
Address 2532 Edmondson Ave. Date signed 2-14-47.

C48651 BCH 466350 BALTIMORE CITY HEALTH DEPARTMENT 45657 ✓ Registered No. C48651

# CERTIFICATE OF DEATH 182a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. 37th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

**3 (a) FULL NAME** Robert Donald Chalk

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 30-1946

8. AGE: Years | Months: 1 | Days: 15 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation: Child

11. Industry or business

FATHER — 12. Name Donald F. Chalk
13. Birthplace Baltimore Md.

MOTHER — 14. Maiden Name Lucille Hroblewski
15. Birthplace New York

16 (a) Informant Donald F. Chalk
(b) Address 1400 W. 37th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 17-1947 (month) (day) (year)
(c) Cemetery or crematory St. Mary's (Hampden)
Location Baltimore, Maryland

18 (a) Funeral director Burger Funeral Home
(b) Address 3031 Falls Road

FEB 17 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 15 1947, at 8:20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Mechanical suffocation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-15-47 at about 6:45 A M(?)
(b) Where did injury occur? 1400 W. 37th St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? —
(d) Means of injury Probably Suffocation

23. Signature Geo. L. Merrill M.D. Medical Examiner.
Date signed 2-15-47

VS 191

X 127

G48652

HOWARD C. STANSBURY

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G48652 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Fullerton (If outside city or town limits, write RURAL and give town)
(d) Street No. Silver Spring Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Howard C. Stansbury

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Minnie P. Stansbury
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 4-1875
8. AGE: Years 72 Months 1 Days 11 If less than one day hr. min.
9. Birthplace Baltimore Co. Maryland (Town, county, and state)
10. Usual Occupation Stone Mason
11. Industry or business Quarry
FATHER 12. Name Richard T. Stansbury
13. Birthplace Maryland
MOTHER 14. Maiden Name Mary C. Neff
15. Birthplace Maryland
16 (a) Informant Hilda P. Stansbury
(b) Address 604 Brookwood Road
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 17-1937 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Friendship, Baltimore Co. Md.
18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road
19 (a) FEB 17 1937 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2-15 1937, at 12:00 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 2-13 1937, to 2-15 1937, and that I last saw h/m alive on 2-15 1937.

| Immediate cause of death | Duration |
|---|---|
| Cerebral hemorrhage | |
| accident | |
| Secondary to Hypertension C.V.D. | |
| Due to | |
| Due to | |
| Other Conditions Diabetes Mellitus, Arteriosclerosis | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. P. Hurley M. D.
Address Univ. Hosp. Date signed

X

G48653

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1310

G48653 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1236 Bonaparte Avenue
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1233 Bonaparte Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** RUTH JANE MEYER

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| NO | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife Henry Wm. Meyer
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) May 8, 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 9 | 5 | ..... hr. ..... min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Klages
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Laura Johnson
15. Birthplace Baltimore, Maryland

16 (a) Informant Mr. Henry Wm. Meyer
(b) Address 1233 Bonaparte Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) FEB 17 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 19 47 at 8P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/23/47 19 .., to 2/13/ 1947.
and that I last saw h.. alive on 2/13/ 1947.

Immediate cause of death Coronary occlusion.
Due to Arteriosclerosis
Due to Chronic Nephritis
Other Conditions Hypertension.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

| Duration | |
|---|---|
| 6 hours | |
| Onset | 1/23/47 |
| 3 | |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Leonard Sander, M.D.
Address 1517 E. Fort Ave. Date signed 2/14/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

548654 BCH F 42993

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Reg. 548654

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 701 Walnut Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 Walnut
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Doris Lynn Hamlet

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1942

8. AGE: Years 5 | Months 1 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Carson Hamlet

13. Birthplace Md

MOTHER 14. Maiden Name Edna Warrington

15. Birthplace Md.

16 (a) Informant Carson Hamlet, Jr

(b) Address 701 Walnut Ave

17 ~~(a)~~ Burial (b) Date thereof Feb. 12 '47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location North Ave & Parkin Rd.

18 (a) Funeral director Harry H. Kirkpatrick

(b) Address 401 Edmondson Ave

19 (a) FEB 7 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

V S 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb 15 1947 at 7:30 PM

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 9 1942 to Feb 15 1947 and that I last saw her alive on Feb 7 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral hemorrhage | 1 hour |
| Due to | |
| Due to | |
| Other Conditions Cerebral hemorrhage at Birth (Include pregnancy within 3 months of death) | |

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23.** Signature J. M. Carson

Address 332 Fillmore Date signed 2/15/47

X

G48655

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G48655 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 139 N. Luzerne Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 33

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 139 N. Luzerne Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Felice Rescigno

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 216-05-9099

4. Sex: male

5. Color or race:

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Maria Rescigno

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) August 8 1891

8. AGE: Years 55 | Months 6 | Days 6 | If less than one day: hr. min.

9. Birthplace Costa Marcato S.Severino Italy (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business Tailor Shop

FATHER
12. Name Nicola Rescigno
13. Birthplace Italy

MOTHER
14. Maiden Name Clementina Pisana
15. Birthplace Italy

16 (a) Informant Maria Rescigno (Wife)
(b) Address 139 N. Luzerne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Belair Rd.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

(a) Date received by registrar FEB 17 1947 (b) Huntington for Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 19 47, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 8 1945 to Feb 14 1947, and that I last saw h[illegible] alive on Feb 14 19 47

Immediate cause of death: Coronary Thrombosis — Duration: 2/14/47

Due to: Chronic Myocarditis — 1/1945

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature William J. Spooner, M.D.
Address 501 N. Eutaw St. Date signed 2/16/47

X

G48656

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1579

G48656 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 218 E. 23rd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 218 E. 23rd St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARVEL A. LEE

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-17-1943

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 3 | 9 | 28 | hr. min. |

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John E Lee
13. Birthplace Md

MOTHER
14. Maiden Name Adelaide Simmons
15. Birthplace Va

16 (a) Informant John E Lee
(b) Address 218 E 23rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 17 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Baltimore County Md

18 (a) Funeral director William L Jackson
(b) Address 916 Penna ave

FEB 17 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 181

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/15/47 19..., at 2:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Congenital Absence Common Bile Duct
Due to
Other Conditions Jaundice Anemia
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis, M.D. Medical Examiner
Date signed 2/15/47

X

G48657 B04 G63382

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓107

G48657 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 917 S. Ellwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 917 S. Ellwood Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** Geraldine Maraki

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 29-46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 2 | 18/7 | hr. min. |

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward Keenan
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Albina Maraki
15. Birthplace Baltimore Md.

16 (a) Informant Albina Maraki
(b) Address 917 S. Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/47 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cem
Location Dundalk Ave

18 (a) Funeral director John F. Duda
(b) Address 2829 Hudson St

19 (a) FEB 17 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 2

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 16 1947, at 2:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14 1947, to Feb 16 1947, and that I last saw her alive on Feb 16 1947.

Immediate cause of death Acute Bronchopneumonia

| | Duration |
|---|---|
| Due to | 2-04-47 |
| Due to | |
| Other Conditions None | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Keenan M. D.
Address 892 N. Eutaw Date signed 2-16-47

G48658

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 122B

G48658 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd Street.
(c) Hospital or institution:
Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 51
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 York Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs. Philip K. Glassner (Ida)

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | M |

6 (b) Name of husband or wife Philip K. Glassner
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Jan 1st 1916

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 31 | 1 | 16 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Hyman Pressman
13. Birthplace Russia

MOTHER
14. Maiden Name Mary Kuttzman
15. Birthplace Russia

16 (a) Informant Philip Glassner
(b) Address 506 York Road

17 (a) Burial (b) Date thereof 2-17-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Philadelphia Hamilton ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 409 E Balto St

19 (a) FEB 17 1947 Huntington Williams, M.D.
(Death record by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 16 1947; at 10 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1947 to Feb 16 1947, and that I last saw h-r alive on Feb. 16 1947

Immediate cause of death: Peritonitis — Duration: 1 mos

Due to: Intestinal Perforation

Due to: Post op. to Gastrectomy — 1½ mos

Other Conditions: Volvulus of Colon

(Include pregnancy within 3 months of death)

Date of operation 1/3/47 & 1/16/47

Major findings of operation: Volvulus at splenic Flexure 1/16/47

of autopsy: Perforation at ~~outer~~ stomach

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Glasgow M.D.
Address Union Mem Hosp Date signed 2/16/47

VS 150

G48659

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 161c

Registered No. G48659

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Rayner Ave 16
(c) Hospital or institution: West Balto Gen Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto 15
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3106 Rockwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joshua Jay Kellner

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | S |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/12/47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 4 | hr. min. |

9. Birthplace Balto Md -
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Maurice Kellner
13. Birthplace Balto. Md -

MOTHER
14. Maiden Name Johanna S Klorens
15. Birthplace Balto Md -

16 (a) Informant Maurice Kellner
(b) Address 3106 Rockwood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17-46 (month) (day) (year)
(c) Cemetery or crematory Mishkan Israel
Location Southern Ave

18 (a) Funeral director Sol Levin Inc
(b) Address 1609 E Balto St

FEB 17 1947 (b) Thurlington Williams M.D. Registrar
(Date rec'd by Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1947, at 9: AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-12 1947 to 2-16 1947, and that I last saw him alive on 2-14 1947.

| Immediate cause of death | Duration |
|---|---|
| Pancreatitis, Hemorrhage & Shock | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not done

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 1 E Balto Gen Hosp Date signed 2-16-47

VS 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18660

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G18660 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 47 years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 516 S. Bond Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Margaret Kunawicz or Mary Kunavich

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Walenyan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | — | — | hr. min. |

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Cedielska
13. Birthplace Poland

MOTHER
14. Maiden Name Julia ?
15. Birthplace Poland

16 (a) Informant Record - Balto. City Hosp.
(b) Address 4940 Eastern Ave

17 (a) Burial (b) Date thereof 2-17-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Sacred Heart of Mary
Location German Hill Road

18 (a) Funeral director John A. Grebiancke
(b) Address 423 S. Paca St.

19 (a) FEB 17 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 191

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 12 1937, at 10 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic heart disease.

Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 2-15-47

G48661

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V 124 B

G48661 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hosp V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 min
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 Marshall St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Joseph Edgar Countess

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Anna L. Lee
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) July 6, (1876) 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| (70) 69 | 7 | 9 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Ship watchman
11. Industry or business U. S. A watchman

FATHER
12. Name Joseph Countess
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Ruth Murray
(b) Address 2819 Winchester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/47 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Annapolis Blvd

18 (a) Funeral director John F Denver Inc
(b) Address 746 Light St

19 (a) FEB 17 1947 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

VS 191

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 15, 1947, at [illegible] M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to Chronic rheumatic heart disease with mitral stenosis

Due to Cirrhosis of liver

Other Conditions Laceration of scalp

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D. (Medical Examiner.)
Date signed 2-15-47

X

G48662 BCH G64428 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 108 G48662 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 7

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4410 St George (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Audra Dorsey G64428 V 20

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/8/46

8. AGE: Years | Months: 3 | Days: 7 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation child

11. Industry or business -

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Marjorie Neal
15. Birthplace Maryland

16 (a) Informant Hopkins records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 17 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Baltimore Md.

18 (a) Funeral director Mrs Robt A Elliott + Dyer
(b) Address 1129 N Curtis St

19 (a) FEB 17 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1947 at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1947 to Feb 16 1947 and that I last saw h[illegible] alive on Feb 15 1947

| Immediate cause of death | Duration |
|---|---|
| Pneumonia + Influenza | |
| Lobar | |
| Due to | |
| | |
| Due to | over |
| Other Conditions | |
| (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address Johns Hopkins Hosp. Date signed 2-15-47

G48663

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1084

G48663 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If exact age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 822 Somerset St
(c) Hospital or institution:
D
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 Somerset St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Leach

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Colored | Married |

6 (b) Name of husband or wife Lucille

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 11 | 11 | hr. min. |

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Edmond Leach
13. Birthplace N. C.

MOTHER
14. Maiden Name Beulah ?
15. Birthplace N. C.

16 (a) Informant Lucille Leach
(b) Address 822 Somerset St

17 (a) Burial (b) Date thereof Feb 16 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Balto County Md.

18 (a) Funeral director Mrs. Robt. A. Elliott
(b) Address 1129 N. Carlton St

19 (a) Feb 17 1947 (b) Huntington Williams, M.D.
(Date filed by registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1947, at 7:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1947 to 2/13 1947 and that I last saw him alive on 2/13 1947.

Immediate cause of death: Lobar Pneumonia — Duration 6 dys

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isaac R. Blake M.D.
Address 1322 N. Charles St

2/17

G48664

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48B

G48664 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1908 E. Fairmount Ave
(c) Hospital or institution: 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 E. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anna Zook

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18-1872

8. AGE: Years 69 | Months 6 | Days 28 | If less than one day ....hr. ....min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business Home

FATHER
12. Name Andrew
13. Birthplace Austria

MOTHER
14. Maiden Name Anna Zarowski
15. Birthplace Austria

16 (a) Informant Catherine Woods
(b) Address 1908 E. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/47 (month) (day) (year)

(c) Cemetery or crematory
Location Catonsville Pa.

18 (a) Funeral director John A. Hogan
(b) Address 300 E. Balto. St

FEB 17 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/15- 1947, at 9.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to Feb 15 1947, and that I last saw h alive on Feb 15 1947.

| Immediate cause of death | Duration |
|---|---|
| CARCINOMA - (UTERUS). | 2 Yrs. |
| Due to | |
| Due to | |
| Other Conditions CEREBRAL HEMORRHAGE | 1 DAY. |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James F Kenney M.D.
Address 3614 Wilkens Ave Catonsville Md Date signed 2-17-47 M. D.

X

G48665

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G48665

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 206 Woodlawn Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 Woodlawn Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** RALPH ROBINSON

3 (b) If veteran, name war: Spanish American
3 (c) Social Security Account No.:

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife: Nettie Robinson
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) June 1, 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 8 | 14 | hr. min. |

9. Birthplace Waverly, Queen Annes County, Md
(Town, county, and state)

10. Usual Occupation Lawyer
11. Industry or business

FATHER
12. Name John M. Robinson
13. Birthplace Eastern Shore, Md.

MOTHER
14. Maiden Name Mariana Winder Emory
15. Birthplace Eastern Shore, Md

16 (a) Informant Mrs Ralph Robinson
(b) Address 206 Woodlawn Rd

17 (a) Burial (b) Date thereof Feb 17 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Annes
Location Annapolis Rd

18 (a) Funeral director Henry W. Jenkins & Bro
(b) Address 1 Mt Auburn & Orchard Sts

FEB (a) 17 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 15 February 1947, at 12 20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1946 to 15 Feb 1947 and that I last saw h[illegible] alive on 15 Feb 1947

| Immediate cause of death | Duration |
|---|---|
| Coronary occlusion with myocardial infarction | 12 hrs. |
| Due to Arteriosclerotic Heart disease | 6 yrs. |
| Due to | |
| Other Conditions Bronchopneumonia | 24 hrs. |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harris F. Klemfeldt M.D.
Address 1101 St. Paul St. Date signed 15 Feb 47

X

C48666

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

131a

Reg. C48666

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 626 N. Stockton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles Thomas

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: none

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | W |

6 (b) Name of husband or wife: Cecelia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| (illegible) 65 | | | hr. min. |

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Thomas Brown
13. Birthplace Md

MOTHER
14. Maiden Name Unsure ?
15. Birthplace Md.

16 (a) Informant Bessie Thomas
(b) Address 1381 N. Woodyear St

17 (a) Burial (b) Date thereof 2/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Wm. H. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) FEB 17 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/11 1947, at 9:00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-Renal Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature G. L. Gubrinski M.D.
Medical Examiner.
Date signed 2/13/47

VS 131

G48667

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G48667 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1922 McCulloh St 2nd floor
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 5 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1922 McCulloh St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Essie Gilmore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5 Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Columbus Gilmore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1883

8. AGE: Years 63 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Charlotte N. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name ?

13. Birthplace North Carolina

MOTHER 14. Maiden Name Hester Watkins

15. Birthplace N. C.

16 (a) Informant Columbus Gilmore Jr

(b) Address 1922 McCulloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-18-47 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Md

18 (a) Funeral director George H. Kelson

(b) Address 1302 Pennsylvania Ave

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 1947, at 8 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-14-1944 to 2-14-1947 and that I last saw her alive on 2-14-1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary thrombosis | |
| Due to Hypertension | 2 yrs. |
| Due to Arteriosclerosis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ed A Penn Peters M. D.

Address 1723 Druid Hill Ave Date signed 2-14-47

VS 150

G48668

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. G48668

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 901 Federhall Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Federhall St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NATHANIEL YATES

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Cora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 55 | Months 5 | Days | If less than one day hr. min.

9. Birthplace N. Carolina (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Edgar Yates
13. Birthplace N.C.

MOTHER
14. Maiden Name Martha ?
15. Birthplace N.C.

16 (a) Informant Henry Morris
(b) Address 1515 E. Leadenhall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/47 (month) (day) (year)
(c) Cemetery or crematory Greenville
Location Greenville N. C.

18 (a) Funeral director Geo. A. Nelson
(b) Address 1303 Preastman St

FEB 17 1947 (Date rec'd by Registrar) (b) Huntington Williams Register

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/15/47 19 , at 7:40 A M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D. (Medical Examiner)
Date signed 2/15/47

VS 151

G48669

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 M

Registered No. G48669

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not guess at anything, but write the exact facts. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1139 N. Candleton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1139 N. Candleton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Wesley H. Thomas

3 (b) If veteran, name war: None
3 (c) Social Security Account No. ?

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | Col | M |

6 (b) Name of husband or wife: Alma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/1/1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 58 | 8 | 13 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name James W. Thomas
13. Birthplace Md.

MOTHER
14. Maiden Name Harriett A. Edwards
15. Birthplace Md.

16 (a) Informant Alma Thomas
(b) Address 1149 N. Candleton Ave

17 (a) Burial (b) Date thereof 2/18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Md.

18 (a) Funeral director Asa G. Kelly
(b) Address 1303 Pleasant St

FEB 17 1947 (b) Huntington-Williams Mfg
(Date rec'd by Registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 14 1947 at 9:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1946 to Feb. 14 1947 and that I last saw h[illegible] alive on Feb 14 1947.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of Alimentary Canal & metatases to | 6 mos |
| Due to Liver | |
| Due to | |
| Other Conditions — | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature T. Franklin Sudler M. D.
Address 1543 Ramsay Ave Date signed 2/17/47

V S 130

X

G48670 BCH BALTIMORE CITY HEALTH DEPARTMENT G48670

G63223 CERTIFICATE OF DEATH 119a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard Co
(c) City or town Simpsonville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Thomas Christian

3 (b) If veteran, name war: —
3 (c) Social Security Account No.:

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 19 1946

8. AGE: Years | Months: 2 | Days: 28 | If less than one day: hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Chas J Christian
13. Birthplace Tenn

MOTHER
14. Maiden Name Clara Bennett
15. Birthplace Tenn

16 (a) Informant Chas J Christian
(b) Address Simpsonville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-47 (month) (day) (year)
(c) Cemetery or crematory St. Johns
Location Elliott City

18 (a) Funeral director F.C. Figgsbottom
(b) Address Elliott City

19 (c) FEB 17 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/17 1947, at 3:37 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 2/17 1947, and that I last saw h.im alive on 2/17 1947.

| | Duration |
|---|---|
| Immediate cause of death Respiratory failure | |
| Due to Chronic malnutrition | |
| Due to Epidemic diarrhea | |
| Other Conditions Records Infant | |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sarah Poole M. D.
Address Simpsonville Md. Date signed 2/17/47

VS 150

G48671

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V/31a

G48671 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2200 Mayfield Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2200 Mayfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Agatha R. Leach

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Wm. Edward J. Leach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3rd 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 59 | 7 | 11 | hr. min. |

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John A. Dunnock
13. Birthplace Md

MOTHER
14. Maiden Name Mary A. Jones
15. Birthplace Md

16 (a) Informant Mrs A. Leach
(b) Address 2200 Mayfield Ave

17 (a) Burial (b) Date thereof Feb 18th 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo B. Leach
(b) Address 1701-03 N. Patterson Park Ave

FEB 17 1947
(Date rec'd by Registrar)

Huntington Williams M.D.
(Signature of Registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14th 1947, at 6.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1947 to Feb 14 1947 and that I last saw h er alive on 19 47

| Immediate cause of death | Duration |
|---|---|
| Uraemia | 2 days |
| Due to Chronic Nephritis (2 years) | 4 yrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank C. Evans M. D.
Address 1129 St Paul Date signed Feb. 17/47

X

G48672 Burial Requested 2-17-1262

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X/159

G48672

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address CATON & WILKENS AVE
(c) Hospital or institution: ST AGNES HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3200 McCulloh Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** BABY BOY ROCK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/16/47

8. AGE: Years | Months | Days | If less than one day hr. 2 min.

9. Birthplace MD (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name PAUL ROCK

13. Birthplace

MOTHER 14. Maiden Name ANN ROCK

15. Birthplace TENN.

16 (a) Informant Mr Rock

(b) Address 3200 McCulloh Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-17th 1947 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Mt Olivet

Location Frederick Road

18 (a) Funeral director Leo D. Brook

(b) Address 1701-03 N Patterson Park

FEB 17 1947 (Date rec'd by Registrar) Huntington Williams (Registrar)

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 2/16 1947, at 12:35 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 2/16 1947

Immediate cause of death Prematurity

| | Duration |
|---|---|
| | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23.** Signature [signature] M. D.

Address St. Agnes Hospital Date signed 2/16/47

VS 150

G48673

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13B

Registered No. G48673

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3107 Rosekemp Ave.
(c) Hospital or institution: 27

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3107 Rosekemp Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** CHARLES HENRY STEHLI

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife: Mary B. Stehli
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1892

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 | 2 | 21 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Examiner of Accounts
11. Industry or business Maritime Commission

FATHER
12. Name Henry Stehli
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Florence Smith
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Mary B. Stehli
(b) Address 3107 Rosekemp Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/47 (month) (day) (year)
(c) Cemetery or crematory [illegible]
Location

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 17 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 15, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 26 1947 to Feb. 15 1947
and that I last saw h alive on 19

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Tuberculosis | 1 yr. |
| Due to | |
| Due to Exhaustion | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Herbert C. Blake M. D.
Address Med arts Bldg Date signed

V S 190

X

G48674

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G48674

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Homewood Apts.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State -- Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Homewood Apts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** WILLIAM E. VOYCE

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| -- | -- |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Carrie M. S. Voyce
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7, 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 4 | 8 | hr. min. |

9. Birthplace Balto.
(Town, county, and state)
10. Usual Occupation Hardware
11. Industry or business Self

FATHER
12. Name Wm. E. Voyce
13. Birthplace England

MOTHER
14. Maiden Name Mary Staler
15. Birthplace ?

16 (a) Informant Mr. Wm. E. Voyce, Jr.
(b) Address Homewood Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 17 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 15 1947, 12 45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1946 to Feb 15 1947
and that I last saw h[illegible]ive on Feb 15 1947.

| Immediate cause of death | Duration |
|---|---|
| Arteriosclerotic Cardio Vascular Disease | 7 |
| Due to Coronary Thrombosis | 2 day |
| Due to | 7 |
| Other Conditions Chronic Nephritis | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hunter E Little M. D.
Address 10 W. Madison St. Date signed

VS 150

G48675

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48B

G48675 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga
(c) Hospital or institution:
Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life 56 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balt
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3412 Georgia Folls Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

**3 (a) FULL NAME** Miss Mary alice Cook

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | No |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | S |

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-1-1846

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 9 | 1 | 16 hr. min. |

9. Birthplace Balt. Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Friedrich Cook
13. Birthplace Balt.

MOTHER
14. Maiden Name Margit Gemisler
15. Birthplace Balt.

16 (a) Informant Miss Mary alice Cook.
(b) Address 3412 Georgia Folls Ave

17 (a) Burial (b) Date thereof 2/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meads and Son
(b) Address 805 N. Calvert St.

19 (a) 2-17-1947 (Date received by registrar) Thurston for Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2-16 1947, at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-11 1947 to 2-16 1947 and that I last saw he alive on 2-16 1947.

| Immediate cause of death | Duration |
|---|---|
| Resp failure | |
| Due to Cerebro Vascular accident | |
| Due to Hypertension + Diabetes mellitus | |
| Other Conditions Co-Uterus and bladder | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Thomas C Peters M. D.
Address Mercy Hospital Date signed 2-16-47

VS 150

G48676

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 186a

Reg. G48676

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure that correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: Univ. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 55
(e) Length of stay in Baltimore (yrs., mos., or days) 6.5 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 Washington Blvd. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Carrie Gang

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | W |

6 (b) Name of husband or wife Henry Gang.
6 (c) If alive, give age 9 years

7. Birth date of deceased (mo., day, yr.) May 4, 1869

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 9 | 11 | hr. min. |

9. Birthplace York, Pennsylvania (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Henry Zachman
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Black
15. Birthplace Germany

16 (a) Informant Ella May Scott
(b) Address 1431 Washington Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-18-47 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Maryland

18 (a) Funeral director George L. Schwab
(b) Address 2101 W. Frederick Avenue

19 (a) FEB 17 1947 (Date rec'd by Registrar) (b) Huntingtown, Calvert Co. Md. (Registration District No.)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Feb 47 19 , at 3:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 22 Dec 1946, to 15 Feb 1947, and that I last saw h alive on 15 Feb 19 47.

| Immediate cause of death | Duration |
|---|---|
| PROBABLE PULMONARY INFARCTION | |
| Due to VENOUS STASIS & BED SORES | |
| HYPOSTATIC PNEUMONIA | |
| Due to | |
| Other Conditions FRACTURE RT HIP. | |

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: NONE
of autopsy: NONE

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 21/2
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence December 19 46 at ? M
(c) Where did injury occur? 1112 Washington Blvd (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, [illegible] public place? Home of home (Specify type of place) While at work? [illegible]
(e) Means of injury Slipped and fell
23. Signature R.E. Bauer M.D.
Address Univ. Hospital Date signed [illegible]

Howard J. Mitchell, M.D.

G48677

BALTIMORE CITY HEALTH DEPARTMENT,

# CERTIFICATE OF DEATH 130

G48677 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2004 Greenmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto Md
(c) City or town Govanstown (If outside city or town limits, write RURAL and give town)
(d) Street No. 2004 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William J. Lucas

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-0802

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Pearl E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10 1892

8. AGE: Years 54 | Months 5 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Conductor

11. Industry or business

FATHER 12. Name John Lucas

13. Birthplace Maryland

MOTHER 14. Maiden Name Mary

15. Birthplace

16 (a) Informant Pearl E Lucas

(b) Address 2004 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/17/47 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location North of Milton ave

18 (a) Funeral director Wm Cook Inc

(b) Address 1217 St Paul St

2-17-1947 (Date filed by registrar) (Signature of registrar)

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb 14 1947 at 11 30 M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 1937 to Feb 14 1947 and that I last saw him alive on Feb 13 1947.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary tuberculosis | 3 mos |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23.** Signature Jack J. Singer

Address 506 E. North ave Date signed 2-16-47 M. D.

VS 150

X

G48678

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 467

G48678 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5117 O'Donnell St.
(c) Hospital or institution:

76

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5117 O'Donnell St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ella Mobray

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widow |

6 (b) Name of husband or wife John R. Mobray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18th, 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 10 1 | 2 29 | hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name John Dasch
13. Birthplace

MOTHER
14. Maiden Name Elizabeth Freitas
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. John H. Kelly
(b) Address 8211 Philadelphia Rd.

17 (a) burial (b) Date thereof Feb. 20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Loraeka Funeral Home
(b) Address 7401 Belair Road
(c) FEB 17 1947 Huntington Williams M.D. Registrar
(Date rec'd by Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 16th 19 47 at 4:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/12 1946 to 2/16 1947, and that I last saw her alive on 2/16 1947.

Immediate cause of death Carcinoma of Uterus — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles F. Long

Address 5214 Eastern Ave Date signed 2/17/47 M. D.

VS 150

X

BCH

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48679 Registered No.

~~G48679~~ G00614 14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 6
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County.....
(c) City or town Baltimor (If outside city or town limits, write RURAL and give town)
(d) Street No. 1633 E. Fayette St. (If rural, give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

**3 (a) FULL NAME** Alex Stewart

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male. | Black. | |

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-26-44

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 2 3 | 9 | 17 | ....hr. ....min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation.....
11. Industry or business.....

FATHER 12. Name George Stewart
13. Birthplace N.C.

MOTHER 14. Maiden Name Majorie Woneack
15. Birthplace N.C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Feb. 18 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Danville Va
Location.....

18 (a) Funeral director Chas. O. Wilson
(b) Address 1000 N. Brantley Blvd

19 (a) FEB 17 1947 (b) Harrington Williams Funeral Home
(Date rec'd by registrar)

VS 150

**MEDICAL CERTIFICATION** E

20. DATE OF DEATH Feb-13 1947, at 11.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-8 1947 to Feb-13 1947, and that I last saw him alive on Feb-13 1947.

| Immediate cause of death | Respiratory failure | Duration |
|---|---|---|
| Due to | Tuberculous Meningitis | |
| Due to | | |
| Other Conditions | | |

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Easton Childs M. D.
Address Johns Hopkins Hosp. Date signed 2-19-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48680

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 166

G48680 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital ?
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 621 N. Chapel St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Senior Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Georgia Bell

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) 9/16/90

8. AGE: Years 46 | Months 4 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Thomas Bell
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Madlene Williams
15. Birthplace unknown

16 (a) Informant Georgia Bell
(b) Address 621 Chappel St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 18. 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Zion Cem
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bentley Ave

19 (a) FEB 17 1947 (Date received by registrar) Huntington Williams M.D.

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 14 1947 at 10 20 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Internal Hemorrhage due to bullet wound of neck

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:.
(a) Date of injury 2-14-47 at 10:15 P M.
(b) Where did injury occur? Wolfe & McElderry St.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Firearms

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed 2-15-47

X

G48681 ✓ G48681

BH G24826

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 2000

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 848 Vine St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Earl Cole

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/13/1945

8. AGE: Years 1 Months 8 Days 29 If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Cole
13. Birthplace unknown

MOTHER
14. Maiden Name Carretta Mathews
15. Birthplace Howard Co. Md.

16 (a) Informant Loretta Mathews
(b) Address 848 Vine St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Chas O. Wilson
(b) Address 1108 Light St

19 (a) (Date rec'd by registrar) Witnington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/2 1947, at 5:05 P M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Malnutrition
over

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. L. Schumbe M.D.
Medical Examiner.
Date signed 2/3/47

VS 194 1 0

X

G48682

# HEALTH DEPARTMENT—CITY OF BALTIMORE

G48682

## CERTIFICATE OF DEATH

937

1. PLACE OF DEATH Dr. Henry C. Barber, Dispensary Clinic

CITY OF BALTIMORE: (No. St. Paul 23rd St. of St. Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 65 yrs. 0 mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME MARIE McMULLEN GARNER

If U. S. Veteran specify WAR

(a) Residence: No. 4604 MAINE AVE. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. Color or Race | 5. Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| F. | W. | married |

6a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Enoch F. GARNER

6. DATE OF BIRTH (month, day, year) Oct. 13, 1881

| 7. AGE | Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|---|
| | 65 | 4 | 3 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore, Md.

FATHER

13. NAME William McMullen

14. BIRTHPLACE (city or town) (State or country) Balto., Md

MOTHER

15. MAIDEN NAME Rosa Bloeder

16. BIRTHPLACE (city or town) (State or country) Maryland

17. INFORMANT Enoch F. Garner

(Address) 4604 Maine Ave.

18. BURIAL, CREMATION, OR REMOVAL

* Place Knickerbocker Cemetery Date 18 Feb. 1947

19. UNDERTAKER Walter Beecher Bradley

(Address) 1922 W. North Ave.

20. FILED 1947 Huntington Williams, M.D. Registrar.

FEB. 17 1947

Westminster, Md.

### MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Feb. 16. 1947

22. I HEREBY CERTIFY, That I attended deceased from Dec 30 1946 to Feb. 16 47

I last saw h alive on Feb 15 1947 Death is said to have occurred on the date stated above, at 6 30 A.M.

The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Chronic Myocarditis | 1946 |
| Congestive Heart Failure | Feb 16 47 |

Other contributory causes of importance:

| | |
|---|---|
| Chronic Medistenitis | 2 |

Was an operation performed? — Date of —

For what disease or injury? —

Name of operation — X Ray

What test confirmed diagnosis? EKG Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify No

(Signed) Harry C. Barber M. D.

(Address) 100 E 21 3rd St

X

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G48683 BC# G66239

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 161c

G48683 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 weeks

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1327 Pentwood Rd. (If rural give location)
(e) Citizen of foreign country? Germany (Yes or No)
If yes, name country

**3 (a) FULL NAME** Hugh James Hochreiter (HOCHREITER)

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife 0
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 30 1915

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 0 | 1 | 18 | hr. min. |

9. Birthplace Baltimore Md (town, county, and state)
10. Usual Occupation clerk
11. Industry or business

FATHER
12. Name Franklin C Hochreiter
13. Birthplace New York

MOTHER
14. Maiden Name Clara Ann Bull
15. Birthplace New York

16 (a) Informant Father
(b) Address 1327 Pentwood Rd, Lefty 12

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19-47 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location City

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT AVE & 22ND ST.

19 (a) (b)
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 17 1947, at 1 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1947 to Feb 17 1947, and that I last saw h[im] alive on Feb 16 1947

| Immediate cause of death | Duration |
|---|---|
| Overwhelming Sepsis | 2 weeks |
| Due to Toxic hepatitis | 2 weeks |
| Due to Septicemia | ? |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation 0
of autopsy Toxic hepatitis, septicemia

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Wm. A. Kimball M.D.
Address Union Mem. Hospital Date signed 2-17-47

VS 150

G48684 ✓ G48684

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 838

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT & SARATOGA.
(c) Hospital or institution:
MERCY HOSPITAL 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALT., MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 E. 23RD ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MR. DARBY E. DUNN

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 76 Months 2 Days 27 If less than one day hr. min.

9. Birthplace IRELAND (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name JOHN M. DUNN
13. Birthplace IRELAND

MOTHER
14. Maiden Name MARGARET GOLDRICK
15. Birthplace ~~IRELAND~~ BALTO., MD

16 (a) Informant MRS. CHAS. F. BLISS
(b) Address 510 E. 23RD ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-19-47 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location CITY

18 (a) Funeral director WIEDEFELD & SON.
(b) Address GREENMOUNT AVE & 22ND ST.

19 1941 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-16 1947, at 9:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-7 1947 to 2-16 1947 and that I last saw HIM alive on 2-16 1947.

Immediate cause of death RESPIRATORY FAILURE. — Duration

Due to CEREBRAL THROMBOSIS

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James A. Roberts M. D.
Address Mercy Hospital Date signed 2-16-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

VS 150

X

G48685

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G48685 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2399 N. Stricker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2399 N Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Spriggs

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Augusta Spriggs
6 (c) If alive, give age Years

7. Birth date of deceased (mo., day, yr.) Sept 14 1873

8. AGE: Years 73 | Months 4 | Days 29 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Porter
11. Industry or business Dept. Store

FATHER 12. Name Andrew A. Spriggs
13. Birthplace Md.

MOTHER 14. Maiden Name Frances Cook
15. Birthplace Md.

16 (a) Informant Jacob Spriggs
(b) Address 1114 Richard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 17, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Wm. Walter Williams
(b) Address 322 N. Stricker St.

19 (a) (Date) (b) Registrar Washington Williams Registrar

FEB 17 1947
VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb - 13 1947, at 12:45 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1946 to Feb 13, 1947 and that I last saw h alive on Feb 12 1947.

Immediate cause of death: Diabetes Mellitus — Duration: 2
Due to: — 1
Due to: —
Other Conditions: Diabetic Coma — 24 hrs
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature [illegible] M. D.
Address 1413 Druid Hill Ave Date signed Feb-14-47

G48686

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

937

Registration No. G48686

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 686 Pierce St
(c) Hospital or institution:
17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 686 Pierce St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Emma Jackson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Col | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-13-1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 7 | — | hr. min. |

9. Birthplace St Marys Co Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Agnes Thomas
(b) Address 686 Pierce St

17 (a) Burial (b) Date thereof 2 18 47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Peters Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pacific ave

19 (a) (Rec'd by registrar) (b) Registrar

2 18 1947

V S 190

Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15, 1947, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3, 1947, to Feb 15, 1947, and that I last saw her alive on Feb 15, 1947

| Immediate cause of death | Duration |
|---|---|
| Broncho-Pneumonia | 2 wks |
| Due to | |
| Due to | |
| Other Conditions Cardio-Vascular. | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Donald Bando M. D.

Address 2448 W. Hill Ave. Date signed 2-17-47

X

G48687 ✓ G48687

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct name is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1716 W Balto St
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 1d
(e) Length of stay in Baltimore (yrs., mos., or days) 47yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltcity
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1716 W Baltimore (If rural, give location)
(e) Citizen of foreign country? - No - (Yes or No)
If yes, name country

**3 (a) FULL NAME** Millicent Estella Stazazer

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife: Carroll B. Hazazer
6 (c) If alive, give age: 68 years
7. Birth date of deceased (mo., day, yr.): April 22 1880
8. AGE: Years 66 | Months 9 | Days 24 | If less than one day: 23 hr. min.
9. Birthplace: Kent Co. Md. (Town, county, and state)
10. Usual Occupation: none
11. Industry or business: none
FATHER 12. Name: Joseph Porter
13. Birthplace: Kent Co. Md.
MOTHER 14. Maiden Name: Tannie Janvier
15. Birthplace: Kent Co. Md.
16 (a) Informant: Mrs. Edgar Price (daughter)
(b) Address: 520 Hamilton Av. - 46 -
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-18-47 (month) (day) (year)
(c) Cemetery or crematory: L. U. Ch. Cemetery
Location: Worton - Kent Co. Md.
18 (a) Funeral director: Stewart Mann Co.
(b) Address: 108 W Mt. Royal
19 (c) (Date rec'd by registrar) FEB 17 1947 (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 15 1947, at 5:05 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 2-10-1947, to 2-15-1947, and that I last saw h.. alive on 2-[illegible]-1947.
Immediate cause of death: Cerebral Hemmorhage — Duration 5 da.
Due to: Hypertension — Unknown
Due to:
Other Conditions: —
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature: Chester Riland, M. D.
Address 2532 Edmondson Ave Date signed 2-17-47

VS 150

X

G48688

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48688 ✓ 830a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 402 N. Robinson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 N Robinson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry H. Zimmerman

3 (b) If veteran, name war: World war No 1.
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Catherine A. Zimmerman. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1897

8. AGE: Years 49 | Months 9 | Days 12 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Trolleyman at
11. Industry or business the Standard at 6

FATHER 12. Name William Zimmerman
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Mida Stumpf
15. Birthplace Baltimore Md

16 (a) Informant Mrs Catherine A. Zimmerman
(b) Address 402 N. Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 20/47 (month) (day) (year)

(c) Cemetery or crematory Balto Nat Cemetery
Location 5310 Frederick Rd

18 (a) Funeral director Edward W. Conkling & Son
(b) Address 924 E. Baltimore St. Williamsport, Md.

19 (a) FEB 17 1947 (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16, 1947, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 30 1946, to FEB 16 1947, and that I last saw him alive on FEB 7, 1947

| | Duration |
|---|---|
| Immediate cause of death: CEREBRAL HEMORRHAGE | 1 day |
| Due to: HYPERTENSION | 6 years |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nada Solberg M.D.
M. D.
Address 310 Hanford Road Date signed Feb 17 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

X

To be supplied G48689

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

180 G48689

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd St. Balt 18, Md.
(c) Hospital or institution:
Union Memorial Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balt., 18
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 Gorsuch Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Stanley Mercer

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb [illegible] 1937

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 9 | 11 | 26 | hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation School.
11. Industry or business

FATHER
12. Name Sidney Mercer
13. Birthplace Georgia

MOTHER
14. Maiden Name [illegible]
15. Birthplace [illegible]

16 (a) Informant Sidney B. Mercer
(b) Address 1105 Gorsuch Ave

17 (a) Burial (b) Date thereof 2-18-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Dayton Ave.

18 (a) Funeral director Elmer W. Confair Son
(b) Address 224 E. Lanvale St.
Huntington Williams, Mgr.

19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 17 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 15 1947, at 5 35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 13 1947 to Feb 15 1947 and that I last saw him alive on Feb 15 1947

| Immediate cause of death | Duration |
|---|---|
| Overwhelming Toxicity | 2 d. |
| Due to 2nd & 3rd degree burns | 3 da. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 9/5
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Feb 13 at 4 45 P M
(c) Where did injury occur? Balt. Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Fire. (Home)

23. Signature Ida M Watkins M. D.
Address Union Memorial Hosp Date signed 15 Feb 47

PS 130

Dr. J.R. Davis, M.D. - by Howard Johnson, M.D. X

G48690

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 52B

G48690 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3500 Clifton Ave.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3500 Clifton Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward B. Sauer

3 (b) If veteran, name war

3 (c) Social Security Account No. 323-01-7292

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Florence M. Sauer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 4 | 27 | hr. min. |

9. Birthplace Philadelphia, Pa.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Transo Envelope Co.

FATHER
12. Name Oscar Sauer
13. Birthplace N. Y.

MOTHER
14. Maiden Name Matilda L. Yungel
15. Birthplace N. Y.

16 (a) Informant Mrs. Florence M. Sauer
(b) Address 3500 Clifton Ave.,

17 (a) Burial (b) Date thereof 2-18-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location New York City, N. Y.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) FEB 17 1947 Huntington Williams, M.D. Registrar
(Date received) (Registrar)

VS 150

**MEDICAL CERTIFICATION** 12.30

20. DATE OF DEATH February 16, 1947 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15 1947 to Feb. 16 1947, and that I last saw him alive on Feb. 15 1947

| Immediate cause of death | Duration |
|---|---|
| Urinemic coma | 2 days |
| Due to Carcinoma of bladder about | 5 years |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hattie Dubbett M.D.
Address 2220 Garrison Blvd. Date signed 2/19/47

X

G48691

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G48691 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 905 W. Lombard St.
(c) Hospital or institution: 18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ALBERT ROBERT LAGENOUR

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Divorced |

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown - 1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | | | hr. min. |

9. Birthplace Indiana (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name Albert Lagenour
13. Birthplace Indiana

MOTHER
14. Maiden Name Unknown
15. Birthplace Indiana

16 (a) Informant Mrs. Jessie W. Hardy
(b) Address 906 Burgundy St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location 2930 Frederick Avenue

18 (a) Funeral director John J. Comas & Son
(b) Address [illegible]

19 (a) FEB 17 1947 (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** February 14, 1947, at 11.30 A M

**21.** I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Malecia M.D.
Medical Examiner.
Date signed 2-14-47

VS 151

X

G48692 Henry Lachmann
2322 Callow Avenue

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 937

G48692 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5620 Greenhill Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5620 Greenhill Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Mary Grace Armstrong

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widowed |

6 (b) Name of husband or wife John A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1861

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 85 | 6 | 30 | 19 hr. min. |

9. Birthplace Chester, England (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Thomas Morgan
13. Birthplace England

MOTHER
14. Maiden Name Sarah ?
15. Birthplace England

16 (a) Informant Mrs. Glorence G. Falls
(b) Address 5620 Greenhill Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

FEB 17 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 15, 1947, at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945, to Feb 15 1947, and that I last saw deceased alive on Feb 15 1947.

Immediate cause of death Cerebral hemorrhage — Duration 17 m.
Due to Arteriosclerosis — 10 years
Due to
Other Conditions Cerebral apoplexy — 2 d.

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Lachmann M. D.
Address 2322 Callow Ave Date signed Feb 18, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48693

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1246

Registered No. G48693

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun St.
(c) Hospital or institution Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County —
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3130 Lawnview ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

**3 (a) FULL NAME** JULIA FAHEY
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | W | MARRIED |

6 (b) Name of husband or wife EDW. J. FAHEY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/2/04

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 42 | 8 | 14 | ___ hr. ___ min. |

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business —

FATHER
12. Name William F. Lembach
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Rosa Jamison
15. Birthplace Balto. Md.

16 (a) Informant Edward J. Fahey
(b) Address 3130 Lawnview Ave

17 (a) Burial (b) Date thereof 2/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

FEB 18 1947
(Date received by Registrar)

(Signature of Registrar) Huntington Williams, M.D.
Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/16 1947 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/7 1947 to 2/16 1947 and that I last saw h. EE alive on 2/16 1947

| Immediate cause of death | Duration |
|---|---|
| HEPATIC CIRRHOSIS | 3 YEARS |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: NOT DONE

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature W. Morton Gratz M. D.
Address Franklin Sq. Hosp Date signed 2/16/47

G48694

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

97

G48694 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 Roslyn Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Frederick
(c) City or town Gen Market
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

2 (a) FULL NAME Ida Glanville

3 (b) If veteran, name war: W
3 (c) Social Security Account No. none
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: William E
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 19. 1860
8. AGE: Years 87 | Months 0 | Days 29 | If less than one day hr. min.
9. Birthplace Illinois (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Lorenzo Bassett
13. Birthplace
MOTHER 14. Maiden Name Almira Bradford
15. Birthplace
16 (a) Informant Cas Glanville
(b) Address 1201 St Paul St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md
18 (a) Funeral director Tilhorn & Son
(b) Address 1217 E Pratt St
19 FEB 18 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1947, at 9 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1947, to Feb. 16 1947, and that I last saw h.e. alive on Feb 15 1947.

| | Duration |
|---|---|
| Immediate cause of death: Acute bronchopneumonia, terminal | (days) |
| Due to: Arteriosclerosis | |
| General senility | |
| Due to: Chronic. | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Bert B. Gaylor M. D.
Address Marion Ark Hosp. Date signed 2/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

File G48695

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 47

Registered No. G48695

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd Street Balt.
(c) Hospital or institution: Union Memorial Hosp. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balt.
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2324 Eutaw Place (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel E. Lafferty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Neil Lafferty

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25 1872

8. AGE: Years 74 Months 5 6 Days 21 If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Retired Librarian

11. Industry or business Peabody

FATHER
12. Name Samuel E Lafferty
13. Birthplace Balt. Md.

MOTHER
14. Maiden Name Mary Bilmeyer
15. Birthplace Balt. Md

16 (a) Informant Mrs Neil Lafferty
(b) Address 2324 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/47 (month) (day) (year)
(c) Cemetery ~~as~~ Cathedral
Location Balto Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1417 St. Paul St.

19 FEB 18 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 15 1947, at 12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 9 1947, to Feb 15 1947, and that I last saw him alive on Feb 15 1947

| | Duration |
|---|---|
| Immediate cause of death: Cardiac Failure | 12 hrs |
| Due to: Post operatively | 4 da |
| Due to: Carcinoma Rectum | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation Feb. 11, 1947
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John H. Chaser M. D.
Address Date signed

G48696

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G48696

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 329 E Lanvale St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 329 E Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Hattie Dwyer Lewis

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife William H. Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 7 | 12 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

| | |
|---|---|
| FATHER | 12. Name Albert Dwyer |
| | 13. Birthplace Harford Co Md |
| MOTHER | 14. Maiden Name Susan Torney |
| | 15. Birthplace Harford Co Md |

16 (a) Informant Edward Lewis
(b) Address O'Donnell Heights

17. Burial (Burial, cremation, or removal) (b) Date thereof 3/19/47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1217 Park Ave

19 (a) FEB 20 1947 Huntington Wilson Registrar
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 15 1947, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1 1947, to 2-15 1947, and that I last saw h alive on 2-15 1947.

Immediate cause of death Cerebral Thrombosis — Duration 2 weeks

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R D [illegible] M. D.
Address 11 E Chase St Date signed 2-17-47

VS 150

G48697

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48697 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 832 E Preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 832 E Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Gertrude M McDowell

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife: Thomas C
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 8 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 11 | 12 | hr. min. |

9. Birthplace Harlan Kentucky (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Washington Smith
13. Birthplace Harlan Ky

MOTHER
14. Maiden Name Lurana Whitaker
15. Birthplace Ky

16 (a) Informant Samuel J McDowell
(b) Address 5211 N Bloom St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/18/47 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie Md

18 (a) Funeral director Tilburn Cole Inc
(b) Address 1217 E Cont St

19 (a) [illegible] (Signature of local registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH July 16 1947, at 3 55/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 1940 to 2/16 1947 and that I last saw her alive on 2/15 1947.

| Immediate cause of death | Duration |
|---|---|
| ARTERIO SCLEROTIC CARDIO VASC DISEASE | few yrs |
| Due to Cerebral Hemorrhage | 3 days |
| Due to | |
| Other Conditions Pulm Tuberculosis Bronchiectasis | 5 or 6 yrs |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo A Weinstock M. D.
Address 4603 Pk Heights Ave Date signed 7/17/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G48698 BCG-70805 CWK-108305

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

161a

Register G48698

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 916 N. Pine Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Girl Crowley -- Maybelle (Mother)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 10-1947

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Edward Crowley
13. Birthplace Virginia

MOTHER — 14. Maiden Name Maybelle Wright
15. Birthplace Virginia

16 (a) Informant Records - Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Feb 14 1947 (month) (day) (year)
(c) Cemetery or crematory Crematory
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

19 (a) FEB 18 1947 (Date received by Registrar) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH February 12 1947 at 8:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1947, to Feb 12 1947, and that I last saw h er alive on Feb. 12 1947.

Immediate cause of death: Cerebral Anoxemia — Duration: 2 days
Due to
Due to
Other Conditions Atelectasis — 2 days
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Atelectasis - Right

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julian P. Griffin M. D.
Address Balt. City Hosps Date signed 14 Feb 1947

VS 150

G48699

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G48699

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1608 Warwick Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 3
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 Warwick Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** HANNAH ZENKER MILHISER.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Benjamin Milhiser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1873.

8. AGE: Years 73 | Months 8 | Days 22 | If less than one day, hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Jacob Senker,
13. Birthplace Germany.

MOTHER
14. Maiden Name Mary Sachs,
15. Birthplace Germany.

16 (a) Informant Mr. Jack Milhiser,
(b) Address 1608 Warwick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2.18.47. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris Sonnenheim & Son
(b) Address 1902 Eutaw Place.

19 (a) FEB 18 1947 (Date received by registrar) Registrar
Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 15th. 1947 at 5:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/18 1947 to 2/15 1947.
and that I last saw h[illegible] alive on 2/15 1947

| Immediate cause of death | Duration |
|---|---|
| Myocarditis | |
| Due to Auricular Fibrillation | |
| Due to Hypertension | |
| Other Conditions Cerebral Sclerosis | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. J. Polanick M. D.
Address 4710 Liberty Hghts Date signed

VS 150

G18700

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G18700 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital W
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 831 South Bond Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Eiser

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | | | hr. min. |

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business
12. Name (FATHER)
13. Birthplace
14. Maiden Name (MOTHER)
15. Birthplace
16 (a) Informant
(b) Address
17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School FEB 13 1947
Location Commissioner of Health
18 (a) Funeral director
(b) Address
19 FEB 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

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## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/30/47 19 , at 9:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Lesion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Stevens M.D. Medical Examiner.
Date signed 1/30/47

X

G18701

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G18701

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 Pierce St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Conklin

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | | | hr. min. |

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Johns Hopkins Medical School FEB 13 1947

18 (a) Funeral director Commissioner of Health
(b) Address

FEB 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 131

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 2/6 1947 at 9:27 P.M.

**21.** I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

**IMMEDIATE CAUSE OF DEATH** Arteriosclerotic C.V. disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Vulpius M.D.
Medical Examiner.
Date signed 2/7/47

G48702 BC# B69539

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓161a

G48702 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) Day
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 N. Hill St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James D. Ragins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/1/47

8. AGE: Years | Months | Days: 3 | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business Infant

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical School

18 (a) Funeral director

(b) Address

FEB 18 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

FEB 14 1947 Commissioner of Health

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 4th 1947 at 5:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Atelectasis of lungs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. (Medical Examiner.)
Date signed 2-4-47

VS 181

G48703

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 163H

Registered No. G48703

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 Thames St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Michael Dommelen

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| W | M | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | | | hr. min. |

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Loc Johns Hopkins Medical School FEB 13 1947

18 (a) Funeral director Commissioner of Health
(b) Address
19 (a) FEB 18 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/19/47 19 at 2:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Carbon Monoxide Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/15/47 at P.M.
(b) Where did injury occur? Home, 1626 Thames St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Self Inflicted - Turned Gas

23. Signature John A. Rivera M.D. Medical Examiner.
Date signed 1/19/47

VS 181

G48704

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 167

G48704 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 720 Bevan Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Joseph Wilson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 44 | | | hr. min. |

9. Birthplace (Town, county, and state)
10. Usual Occupation Unknown
11. Industry or business

FATHER 12. Name
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School FEB 13 1947
Commissioner of Health

18 (a) Funeral director
(b) Address

FEB 18 1947 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

**MEDICAL CERTIFICATION** 30

20. DATE OF DEATH January 25 1947, at 9P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage due to severed blood vessel. (External iliac artery, left).

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/25/47 at 12 45 A. M.
(b) Where did injury occur? 720 Bevan Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Sharp instrument

23. Signature Howard J. Mancini M.D. Medical Examiner.
Date signed 1/28/47

VS 131

G18705

BC# 470049

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 160a

G18705 Registered No.

MARGINS RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 day
(e) Length of stay in Baltimore (yrs., mos., or days) 5 day

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Patricia Ann Offenbacker

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | newborn |

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 4. 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 5 | hr. min. |

9. Birthplace University Hospital
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name William Frederick Offenbacker
13. Birthplace Virginia

MOTHER 14. Maiden Name Virdie Edith Gordon
15. Birthplace Doncaster, Md

16 (a) Informant Virdie Edith Offenbacker
(b) Address 1317 W. Fayette St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School FEB 13 1947
Commissioner of Health

18 (a) Funeral director
(b) Address

FEB 18 1947 (Date received by registrar) (b) Huntington Williams M.D.

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb. 9 1947, at 10 35 A. M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Feb. 4 1947, to Feb. 9 1947, and that I last saw her alive on Feb. 9 1947.

| Immediate cause of death | Duration |
|---|---|
| Intracranial Hemorrhage | |
| Due to Birth injury | |
| Due to — | |
| Other Conditions — | |

(Include pregnancy within 3 months of death)
Date of operation None Feb 4, 1947
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23.** Signature Robert E. McCurdy M. D.
Address University Hosp Date signed 2/9/47

X

G48706 BCH 9369655

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓1600

G48706 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1323 west Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Donovan Debois DU-BOIS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 24 1947

8. AGE: Years | Months | Days: 16 | If less than one day: hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business —

FATHER 12. Name Earl Du Bois

13. Birthplace Md

MOTHER 14. Maiden Name Mary Williams

15. Birthplace Md

16 (a) Informant Mr Earl Du Bois

(b) Address 1323 W. Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/47 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Balto Md

18 (a) Funeral director Geo E Beyer Jr

(b) Address 1512 Hollins St

FEB 18 1947 (Date rec'd by Registrar) (b) Huntington for Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 17, 1947, at 7 30 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.

Date signed 2/17/47

VS 181

G48707

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 52 B

G48707 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR ENDING

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address 2000 W Fayette St

(c) Hospital or institution: Bon Secours Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 d.

(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 827 Hollins St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Joseph Narbut Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-12-2949

4. Sex Male

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lebila

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER

12. Name ?

13. Birthplace Lith

MOTHER

14. Maiden Name ?

15. Birthplace Lith

16 (a) Informant William Narbut

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-20-47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem.

Location Belair Rd.

18 (a) Funeral director Joseph Kaznakos Jr.

(b) Address 600 N Paca St. Balto.

19 (a) FEB 18 (Date filed by registrar) (b) 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 16, 1947, at 11 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2-1947 to 2-16 1947. and that I last saw him alive on 2-16 1947.

Immediate cause of death Cardiac failure — Duration

Due to Arteriosclerotic CV disease

Due to

Other Conditions Lobar Pneumonia Ca of bladder; BPH.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature R. L. Shapkey, M.D.

Address Bon Secours Hosp. Date signed 2-18-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48708

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G48708

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State NJ (b) County
(c) City or town Camden (If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 S. Octagon Rd. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** Cook, Owen V.L. (also known as Robert Owen Cook)

3 (b) If veteran, name war ?

3 (c) Social Security Account No. 140-12-8115

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Divorced |

6 (b) Name of husband or wife Grace Cook
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1906

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 40 | 5 | 11 | hr. min. |

9. Birthplace Temple, Texas (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Seafarer

FATHER
12. Name Wm. Mack Cook
13. Birthplace Temple, Texas

MOTHER
14. Maiden Name May Day
15. Birthplace Ga.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 19 47 (month) (day) (year)
(c) Cemetery or crematory Loraine Cemetery Location York Road
18 (a) Funeral director Arlen Funeral Home Inc.
(b) Address 403-6-25th St.
19 (a) (b) Registrar

FEB 18 Pending for Williams

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 14 1947, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 29 1947 to Feb. 14 1947, and that I last saw him alive on Feb. 14 1947

| Immediate cause of death | Duration |
|---|---|
| Tumor of the cerebellum, cystic | 15 yrs |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 2-13-47
Major findings of operation: Tumor of cerebellum, cystic
of autopsy: as above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 2/15/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48709

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13B

G48709 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 840 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Jones, William Frederick

3 (b) If veteran, name war: WWI
3 (c) Social Security Account No.: ?

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Emma Preston Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1893

8. AGE: Years 53 | Months 10 | Days 20 | If less than one day: hr. min.

9. Birthplace Dunkirk, NY
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Clyde Frederick Jones
13. Birthplace NY

MOTHER
14. Maiden Name Alice ?
15. Birthplace NY

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-20-47 (month) (day) (year)
(c) Cemetery or crematory Md. National Cemetery
Location Bath Md

18 (a) Funeral director Oehler Funeral Home Inc.
(b) Address 403-E-25th St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 18 FEB 18 1947 Huntington Woodcock

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 14 1947 at 1:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 12 1947 to Feb. 14 1947, and that I last saw him alive on Feb. 14 1947

Immediate cause of death: Thrombosis of the right internal carotid and middle cerebral arteries — Duration: unk.

Due to: with encephalomalacia of the right cerebral hemisphere. — Duration: unk.

Due to:

Other Conditions: Tuberculosis of lungs, bilateral for advanced (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John B. Spriggs M. D.
Address Marine Hospital Date signed 2/17/47

83C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48710

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G48710

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3801 Beech Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town 3801 Beech Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** David Fulton Hawk

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Barbara Hawk
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Oct 11th 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 4 | 4 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Patrolman
11. Industry or business Self

FATHER
12. Name Dont Know
13. Birthplace Baltimore

MOTHER
14. Maiden Name Dont Know
15. Birthplace Baltimore

16 (a) Informant Mrs Barbara Hawk
(b) Address 3801 Beech Ave

17 (a) Burial (b) Date thereof Feby 19 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Arlington St

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 18 1947

Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 18th 1947, at 10:05 M

21. I certify that death occurred on the date above stated that I attended deceased from 1/24 1947 to 2/15 1947 and that I last saw h alive on 2/15 1947

Immediate cause of death

| | Duration |
|---|---|
| Cerebral Hemorrhage | 1/24/47 |
| Due to Coronary Thrombosis | |
| Due to Arterial Hypertension | 1947 |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas W Cushen M.D.
Address 2145 W Balto St Date signed 2/16/47

G48711

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48711

Registered No. 93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address. Caton & Wilkens Ave.
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:** Montgomery
(a) State Md. (b) County Silver Springs
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10202 Lorraine Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Sarah Elizabeth Sandholt

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife George Sandholt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14-1860

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 86 | 7 | 4 | hr. min. |

9. Birthplace Troy NY
(Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

**FATHER**
12. Name Wm Hattee
13. Birthplace England

**MOTHER**
14. Maiden Name Elizabeth Sheppard
15. Birthplace England

16 (a) Informant Mr Fred Coonley
(b) Address Silver Spring Md

17 (a) Removal (b) Date thereof Feby 18
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oakdale Park Cem.
Location Catonsville Md

18 (a) Funeral director Leerich Funeral Home
(b) Address 2008 Pleasant St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

FEB 18 1947

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 2-18 1947, at 5 45 M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2-16 1947 to 2-18 1947 and that I last saw h[illegible] alive on 2-17 1947.

| Immediate cause of death | Duration |
|---|---|
| Acute cardiac dilatation | |
| Due to Hypertensive - arterio-sclerotic Heart disease | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature Henry W. Holles M. D.
Address St. Agnes Hosp. Date signed

VS 150

X 2-18-47

G48712

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48712 Registered No. 157E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Kansas (b) County
(c) City or town Stafford (If outside city or town limits, write RURAL and give town)
(d) Street No. 313 Union St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Betty Ann Whitzel

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | - |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-31-42

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 4 | 3 | 16 | hr. min. |

9. Birthplace Kansas (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Paul Whitzel
13. Birthplace Kansas

MOTHER — 14. Maiden Name Laura Wallace
15. Birthplace Kansas

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/18/47 (month) (day) (year)
(c) Cemetery or crematory
Location Sterling, Kansas

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registered #

FEB 18 1947

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb. 17, 1947, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 14 1947, to Feb. 17 1947, and that I last saw her alive on Feb. 17 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral anoxia | |
| ARRHYTHMIA | |
| Due to Cardiac Arrhythmia | |
| Due to Tetralogy of Fallot | Live |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation 2/13/47

Major findings of operation: Cardiac arrhythmia

of autopsy: Tetralogy of Fallot

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry E. Bahrs
Address Johns Hopkins Hospital Date signed 2/19/47

VS 150

G48713

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

Registered No. G48713

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3703 Nortonia Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-9
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town 3703 Nortonia Rd.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** JOHN H. WOLLENBERG

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 218-10-2452

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widow |

6 (b) Name of husband or wife: Minnie Haunert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 6 | 11 | hr. min. |

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Gauger - retired
11. Industry or business: U. S. Indus. Alcohol Co.

FATHER
12. Name: Herman Wollenberg
13. Birthplace: Germany

MOTHER
14. Maiden Name: Elizabeth Guntrum
15. Birthplace: France

16 (a) Informant: Mrs. Marie E. Barnes
(b) Address: 3703 Nortonia Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/47 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) FEB 19 1947 (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 16, 1947 at 9:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/16 1946 to 2/16 1947 and that I last saw him alive on 2/16 1947

Immediate cause of death: Cerebral hemorrhage — Duration: 4 days

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Patient A. Reite M. D.
Address: 3408 Windsor Ave. Date signed 2/17/47

V S 150

Huntington Williams, M.D.

G48714

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G48714

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1700 Park Ave.
(c) Hospital or institution: Wheeler Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1502 Round Hill Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ANNIE G. SCHUSTER

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | white | widow |

6 (b) Name of husband or wife George Schuster
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 4 | 4 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John T. Cullimore
13. Birthplace N. Y.

MOTHER
14. Maiden Name Esther E. Nelson
15. Birthplace Md.

16 (a) Informant Mr. Nelson Schuster
(b) Address 1502 Round Hill Rd. 18

17 (a) Burial (b) Date thereof 2/18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md. for William

19 (a) (b)
(Date rec'd by registrar) Registrar
FEB 18 1947

V S 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 16, 1947, at 6:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1946, to Feb 16 1947, and that I last saw he ed alive on Feb 15 1947.

| Immediate cause of death | Duration |
|---|---|
| Broncho-pneumonia | 2 days |
| Due to Cardio-Vas-Hypertensive Disease | 5 yrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Homer L. Dodd M. D.
Address 2108 St Paul St Date signed 2-17-47

X

G48715

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V 46E

Registered No. G48715

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1005 N. Monroe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 N. Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARY S. TOWNSEND

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | no |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Francis H. Townsend
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 8 | 9 | hr. min. |

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William G. Holmes
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Tucker
15. Birthplace Md.

16 (a) Informant Mrs. Mildred T. Jones, daughter
(b) Address 1005 N. Monroe St.

17 (a) Burial (b) Date thereof 2/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 18 1947

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16, 1947, at 2:46 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 12 1946 to Feb 16 1947, and that I last saw her alive on Feb. 15, 1947.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma Sigmoid | |
| Due to | |
| Due to | |
| Other Conditions Intestinal Obstruction | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George E. Shannon M.D.
M. D.
Address 828 Medical Arts Bldg. Date signed 2/17/47

Huntington Williams, M.D.

X

G48716

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 95B

G48716 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 202 N. Fremont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country.

**3 (a) FULL NAME** Bessie Scribner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ernest

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1904

8. AGE: Years: 42 | Months: 8 | Days: 26 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Britt
13. Birthplace North Carolina

MOTHER
14. Maiden Name Laura Gadding
15. Birthplace North Carolina

16 (a) Informant Mr. Ernest Scribner
(b) Address 202 N. Fremont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Md.

18 (a) Funeral director A. Halstead
(b) Address 916 Druid Hill Ave.

19 (a) FEB 18 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** February 17 1947, at 2:45 P M

**21.** I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rheumatic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 2/17/47

X

G48717

CWK-106722

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G48717

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-8-8
(e) Length of stay in Baltimore (yrs., mos., or days) 23-8-17

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1834 N. Chapel Straat (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Margarete Gwilliems (Margaret N. Gwilliam)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 219-16-3475

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edward R. Gwilliam

6 (c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.) May 30-1923

8. AGE: Years 23 | Months 8 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: George January
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Anna Brooks
15. Birthplace: Maryland

16 (a) Informant: Records-Balto. City Hospitals
(b) Address: 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/47 (month) (day) (year)
(c) Cemetery or crematory: Morelands Park
Location: Taylor Avenue, Balto: Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 FEB 18 1947 (Date received by registrar) Washington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 19 47 at 12:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 9 19 46 to Febr. 17 19 47 and that I last saw her alive on Feb. 17 19 47.

Immediate cause of death: Pulmonary Tuber culosis — Duration: 4-5 months

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: N. Schuler, M.D.
Address: Baltimore City Hosp. Date signed 17 Feb 47

VS 150

B48718 BC# 066725 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 107 Registered No. B48718

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Delaware Ave. St.
(c) Hospital or institution:
Univ. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 24 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 501 Aisquith Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Weinfeld

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Bl.

6 (a) Single, married, widowed, or divorced. Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 5. 1947

8. AGE: Years | Months 1 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Samuel Weinfield
13. Birthplace Petersburg Va

MOTHER
14. Maiden Name Daisy Taylor
15. Birthplace Petersburg Va

16 (a) Informant Samuel Weinfield
(b) Address 501 Aisquith Street

17 (a) Burial (b) Date thereof February 18 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore city

18 (a) Funeral director Joseph A. Hardy
(b) Address 660 W Lane Street

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 1947 at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1947 to Feb. 14 1947 and that I last saw him alive on Feb. 14 1947

| Immediate cause of death | Duration |
|---|---|
| Dehydration & malnutrition | |
| Due to Bronchopneumonia | |
| Due to endocrine disorder | |
| Other Conditions Polycystic disease of pancreas, liver & kidneys | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles R. Johnson
Address Univ. Hosp. Date signed M. 2/15/47 D.

VS 150

Dr. Battaglia
5829 Belair Road

G4871

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94 G4871

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4425 Parkmont Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4425 Parkmont Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Frank Wyatt

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Clara B. Wyatt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13, 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 7 | 4 | hr. min. |

9. Birthplace Calhoun, Georgia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Frank Wyatt
13. Birthplace Ga.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Clara B. Wyatt
(b) Address 4425 Parkmont Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/47 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) FEB 19 1947 (Date received by Local Registrar) (b) Huntington W.H. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1946 to Feb 17 1947 and that I last saw h[illegible] alive on Feb 15 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | 6 yrs |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. F. Battaglia M. D.
Address 5829 Belair Rd Date signed 2/19/47

Dr. Hornstein
Aisq[illegible]son

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947 G48720

G48720

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2900 Markley Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 Markley Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary A. Lavezza

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widowed |

6 (b) Name of husband or wife Anthony A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 5 | 3 | hr. min. |

9. Birthplace New York
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Dominick Noce
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace Italy

16 (a) Informant MISS Lavezza
(b) Address 2900 Markley Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date received by registrar) (b) Registrar
FEB 18 1947 Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 16, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/13 1947, to 2/16 1947, and that I last saw h[illegible] alive on 2/16 1946

| Immediate cause of death | Duration |
|---|---|
| Acute Cerebral Hemorrhage | |
| Due to Generalized arterio sclerosis | |
| Due to | |
| Other Conditions Dr Diabetes | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. L. Hornstein M. D.
Address 733 Aisquith St. Date signed 2/17/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G4872 6CA F58473 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 82a D. 49824 Registered No. G4872

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 3/4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2911 Arlington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jane PECORA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex FE Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24-1942

8. AGE: Years 4 | Months 4 | Days 24 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Ned Pecora
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Felaccatt
15. Birthplace Italy

16 (a) Informant Mr. Ned Pecora
(b) Address 2911 Arlington Ave.

17 (a) Burial (b) Date thereof 2/20/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Baltimore

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 1947, at 10:45 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Edema

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 2/17/47

G48722

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G48722
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3623 Malden Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3623 Malden Avenue
(If no definite location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Helen Gertrude Frock

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife George F. Frock

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 30-1860

8. AGE: Years 87 Months 0 Days 15 If less than one day hrs. min.

9. Birthplace Smithburg Maryland
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Claude Yeakle

13. Birthplace Maryland

MOTHER 14. Maiden Name Lovinie Eichelberger

15. Birthplace Maryland

16 (a) Informant Mrs. Elsie May Greeley

(b) Address 3623 Malden Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 18-1947 (month) (day) (year)

(c) Cemetery or crematory Laters Baptist

Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 15 1947, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to Feb 15 1947 and that I last saw h r alive on Feb 17 19 47

Immediate cause of death

(a) Cerebrovascular CVD

(b) Decomp.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

| Duration |
|---|
| 2 yrs |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laurence L. Clement M. D.

Address 3711 Dalrymple Date signed 2-17-47

VS 150

G48723

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. G48723

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 708 N. 34th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 708 N. 34th Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Robert Franklin Litchfield

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5 1904

8. AGE: Years 43 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Joseph Franklin Litchfield
13. Birthplace Maryland

MOTHER
14. Maiden Name Minnie F. Dailey
15. Birthplace Maryland

16 (a) Informant Mrs. George Sterne
(b) Address 708 N. 34th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 19 1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Gaffs Road

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 16 1947 at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1946 to Feb 16 1947 and that I last saw h[illegible] alive on Feb 15 1947

Immediate cause of death Myocardial Insufficiency — Duration —
Due to Cerebral Hemorrhage
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: No

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature [illegible] M. D.
Address 3949 Charles St Date signed 2/17/47

VS 150

G48724

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G48724

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 719 Harvey St
(c) Hospital or institution: 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 719 Harvey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John James Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Lear Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10, 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 5 | 7 | hr. min. |

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Smith
13. Birthplace New York

MOTHER
14. Maiden Name Not known
15. Birthplace New York

16 (a) Informant Lear Smith
(b) Address 719 Harvey St

17 (a) Buried (b) Date thereof 2-20-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Balt Md

18 (a) Funeral director Frank Groeber
(b) Address 900 Gay Street

19 (a) (Date rec'd by registrar) (b) Registrar

VS 1 FEB 18 1947 Huntington Williams, Inc.

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 1947 at 11:45 A.M.

21. I certify that I took charge of the remains described above, held an ~~Insp.~~ Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mussen M.D.
Medical Examiner.
Date signed 2-17-47

Birth certificate
B-48725
B-71019

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1600

G48725
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Clever & Caroline Sts.
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 32 hrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 N. Highland Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy Parks

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M. | W. | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/16/47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 1 | 32 hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Walter W. Parks Sr.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Helen A. Coker
15. Birthplace Baltimore, Md.

16 (a) Informant Mother
(b) Address 114 N. Highland Ave.

17 (a) Burial (b) Date thereof Feb 18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cath Forest Park
Location Baltimore
18 (a) Funeral director Philip Perini Sons
(b) Address 2024 Eastern Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 18 1947 Huntington Maryland, Md.

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb. 17, 1947, at 7:6 M

21. I certify that death occurred on the date above stated, that I attended deceased from Feb. 16, 1947 to Feb 17, 1947 and that I last saw h[im] alive on Feb. 17 1947.

| Immediate cause of death | Duration |
|---|---|
| Intracranial Hemorrhage. | |
| Due to Premature. | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lieutenant H. Lowe M. D.
Address St. Joseph's Hosp Date signed 2/17/47

X

G48726

BC#
G 70550

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

159

Registered No. G48726

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Madison and Linden Ave
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 346 Roslbank Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy Herzog

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Newborn |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-12-47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 1 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Donald Joseph Herzog
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Winifred Claire Callahan
15. Birthplace Balto. County

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 17 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 18 1947 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 2-12 1947, at 2:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-12 1947, to 2-12 1947, and that I last saw h alive on 2/12/47

| Immediate cause of death | Duration |
|---|---|
| Premature birth (5 month pregnancy) | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Thomas C. Webster, M. D.
Address Md. Gen. Hosp. Date signed

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~H 48727~~ C48727

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. C48727

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 214 S. Robinson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Frederick Heinbuch

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Lillian
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 0 | 14 | hr. min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Musician - Teacher
11. Industry or business

FATHER
12. Name Thomas
13. Birthplace Md.

MOTHER
14. Maiden Name Louise
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North. Ave.

18 (a) Funeral director John A. Hyde
(b) Address 3002 E. Balto. St.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 18 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 16 1947 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 14 1947 to Feb. 16 1947, and that I last saw h. alive on Feb. 16 1947

| | Duration |
|---|---|
| Immediate cause of death: Cerebral hemorrhage | 2 days |
| Due to: Hypertension Cardio vascular disease | 10 yrs |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C. R. Hoffman M. D.
Address Baltimore City Hosp. Date signed 17 Dec 47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48728

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

937

G48728
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Avenue
(c) Hospital or institution:
Harford Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4515 Weitzel Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ROWENA SLOVER

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widow |

6 (b) Name of husband or wife: Alfred T. Slover
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 24, 1860

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 86 | 1 | 23 | hr. min. |

9. Birthplace: Maryland
(Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: George Willey
13. Birthplace: Maryland

MOTHER
14. Maiden Name: ? Saunders
15. Birthplace: Maryland

16 (a) Informant: Mrs. Howard Crawford
(b) Address: 3708 Kimble Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/47 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS
(b) Address: NORTH AVE. & BROADWAY

19 (a) Washington Irvine Williams, M.D. (Date received by registrar) Registrar

FEB 18 1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 16 1947, at 6 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 to 2-16 1947
and that I last saw h alive on 1-12 1947

Immediate cause of death: Myocardial Failure — Duration: 45 days
Due to: Chronic Myocarditis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature: C. W. Peake M. D.
Address: 4518 Harford Road Date signed 2-17-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48729 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G48729 Registered No.

# CERTIFICATE OF DEATH 30c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6911 Belair Rd. (If rural give location)
(e) Citizen of foreign country? [illegible] (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Charles McCord

3 (b) If veteran, name war ?

3 (c) Social Security Account No. 213-03-8042

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife. Hazel R. McCord
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 0 | 8 | hr. min. |

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Manufacturer

11. Industry or business Hollingsworth Machine

FATHER
12. Name Charles T. McCord
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Minnie Schultz
15. Birthplace Baltimore, Maryland

16 (a) Informant Hospital Record
(b) Address Mercy Hosp. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

FEB 18 1947

19 (a) (Date rec'd by registrar) (b) Hester Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 17 1947; at 2 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1947, to Feb 17 1947 and that I last saw h. alive on Feb 16 1947

Immediate cause of death resp. failure — Duration

Due to Syphilitic Pneumonitis & C N S Syphilis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurence J. Kirk M. D.
Address Mercy Hosp. Date signed 2-17-47

VS 130

G48730

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 92D

G48730 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 315 ST. DUNSTANS ROAD
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 315 St. Dunstans Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** EMMA VIRGINIA MAULER

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Conrad Mauler

6 (c) If alive, give age: 82 years

7. Birth date of deceased (mo., day, yr.): April 27, 1866

8. AGE: Years: 80 | Months: 9 | Days: 18 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: James M. Spence
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Rose Stahl
15. Birthplace: Maryland

16 (a) Informant: Mr. Conrad Mauler
(b) Address: 315 St. Dunstans Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-18-47 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS
(b) Address: NORTH AVE. & BROADWAY

19 (a) FEB 18 1947 (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: February 14, 1947, at 10.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from October 1938 to February 1947 and that I last saw h.. alive on Feb 14 1947

| Immediate cause of death | Duration |
|---|---|
| chronic myocarditis | 6 months |
| Due to arterio sclerosis | |
| Due to | |
| Other Conditions arterio. chronic kidn. hip. | 5 years |

(Include pregnancy within 3 months of death)

Date of operation: none.

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Harold Smith, Jr. M.D.

Address 1014 St Paul St. Date signed 2/17/47

V$ 190

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48731
CWK-106815

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 1248

G48731
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 5-
(e) Length of stay in Baltimore (yrs., mos., or days) 43- 3- 8-

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town 632 N. Collington Avenue
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Randolph Brooks Bafford

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-16-5077

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 9-1903

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 43 | 3 | 8 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Bar Tender
11. Industry or business

FATHER
12. Name Randolph Brooks Bafford
13. Birthplace Maryland

MOTHER
14. Maiden Name Clara Weber
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) Huntington Williams M.D. (Date rec'd by registrar) Registrar

FEB 18 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 1947, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12 1940 to Feb. 17 1947 and that I last saw him alive on Feb. 17 1947.

| Immediate cause of death | Duration |
|---|---|
| Portal hypertension | 1 yr |
| Due to Cirrhosis of liver | 4 & 6 yrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 2-5-47
Major findings of operation: as above
of autopsy: as above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Jonall M.D.
Address Balto. City Hosp. Date signed 2-19-47

G48732

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

186a G48732

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Lay near + Dulaland
(c) Hospital or institution West Baltimore Gen Hosp. 2 months
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1951 W. Lafayette ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Scheibel

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband: Charles Scheibel
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Aug 13th 1875
8. AGE: Years 71 | Months 6 | Days 4 | If less than one day hr. min.
9. Birthplace Stafford Del (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Ethel Ash
(b) Address 2025 Raynor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/47 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) Huntington Williams M.R. (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 17 February 1947 at 3 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 Dec 1946 to 17 Feb 1947 and that I last saw h.e.r. alive on 17 Feb 1947

| Immediate cause of death | Duration |
|---|---|
| Lung Sarcoma | |
| Due to Pneumonia, Lobar, bilateral | |
| Due to | |
| Other Conditions Gen-Arteriosclerosis Rt. Femoral Head Fracture | |

(Exclude pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 5/2
(a) Accident, suicide, or homicide accident
(b) Date of occurrence December 15 1946 at 8 P M
(c) Where did injury occur? North + Fulton Ave. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? public (Specify type of place) While at work? no
(e) Means of injury Stepped into hole fell & struck

23. Signature Louis A. Drace M.D.
Address [illegible] Date signed 2/17/47

FEB 18 1947 for A. W. S. Hosford, by Thomas J. Williams, M.D.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G48733

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G48733 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) DIA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 N. Patterson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 55 | Months 54 | Days | If less than one day hr. min.

9. Birthplace Wythville Va.
(town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Thomas Johnson
13. Birthplace Wythville Va.

MOTHER
14. Maiden Name Nelvina King
15. Birthplace Wythville Va.

16 (a) Informant Daniel Johnson
(b) Address 1065 S. 9th St. Harrisburg Pa.

17 (a) Burial (b) Date thereof Feb 19 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Balto. National Cem
Location

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 325 W. Lexington St.

19 (a) FEB 18 1947 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 1947, at 7.20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. D. Lubowski M.D.
Medical Examiner.
Date signed 2/16/47

VS 191

Bowen

G48734

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 92a

G48734

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 775 George St.
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 775 George St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Bowen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Georgianna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1891

8. AGE: Years 56 | Months 11 | Days 14 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Horseman

11. Industry or business

FATHER
12. Name William H. Bowen Sr.
13. Birthplace Md.

MOTHER
14. Maiden Name Isabella
15. Birthplace Md.

16 (a) Informant Chas. Bowen Jr.
(b) Address 775 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 19 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St. Huntington Williams, Md.

19 (a) 1947 (Date received by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 16 1947 at 6 H. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-10 1947 to 2-16 1947 and that I last saw h. alive on 2-15 1947.

| | Duration |
|---|---|
| Immediate cause of death: Aortic Heart Disease | 3 |
| Due to: | |
| Due to: | |
| Other Conditions: Myocardial Infarct (Include pregnancy within 3 months of death) | 3 |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature
Address 761 Hollins Date signed 2-17-47

VS 150

G18735

BALTIMORE CITY HEALTH DEPARTMENT ✓ G18735 Registered No.

# CERTIFICATE OF DEATH 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 311 N. Gilmore St.
(c) Hospital or institution:
19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 311 N. Gilmore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles F Fletcher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Georgiana

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 3 | 20 | hr. min. |

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Boot Black

11. Industry or business

FATHER
12. Name Spencer F Fletcher
13. Birthplace U.S.A. Co. Md.

MOTHER
14. Maiden Name Lucy Kellum
15. Birthplace Va.

16 (a) Informant Delaphine Gray
(b) Address 1719 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 18, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katy R. Williams
(b) Address 322 N. Schroeder St

19 (a) 1947 (Date rec'd by registrar) (b) Katy R. Williams, M.D. Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 2-14 1947 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/12 1947 to 2/14 1947, and that I last saw h. alive on 2/12 1947

| Immediate cause of death | Duration |
|---|---|
| Cardiac vascular renal disease | |
| Due to Hypertension | 1 yr |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. W. Lucas M.D.
Address 1600 Edmondson Ave Attended

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48736

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 170c

G48736 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1829 N. Castle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: William Wirth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Martha Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13th 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | 0 | 3 | hr. min. |

9. Birthplace: Balto
(Town, county, and state)

10. Usual Occupation: Bricklayer (Retired)

11. Industry or business

FATHER
12. Name: Henry Wirth
13. Birthplace: Balto Md

MOTHER
14. Maiden Name: Not known
15. Birthplace: "

16 (a) Informant: Mrs. Earl Blunder
(b) Address: 1829 N. Castle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/47 (month) (day) (year)

(c) Cemetery or crematory: Balto.
Location: Balto. Md.

18 (a) Funeral director: E. J. Fanning & Son
(b) Address: 1938 E. Lafayette Ave.

19 (a) Filed FEB 18 1947 (b) Registrar
(Registrar's signature)

VS 181

## MEDICAL CERTIFICATION

20. DATE OF DEATH: February 16 1947, at 2 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Burns of Head & Hemorrhage
Comminuted fracture of Tibia & fibula. Fractured ribs.

Due to

Other Conditions: Generalized arteriosclerosis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following: 8/5

(a) Date of injury 1-6-47 at 6:50 P M.
(b) Where did injury occur? Chester St. & North Ave
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Pedestrian struck by truck

23. Signature: Howard J. Maddox M.D.
Medical Examiner.
Date signed 2-17-47

Registrar

Huntington Williams, M.D.

X

G48737

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

937

Registered No. G48737

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2544 W. FAYETTE St
(c) Hospital or institution: no

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 2544 W. FAYETTE St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA E. HEIM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband ex-wife GEORGE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR-11-1882

8. AGE: Years 64 | Months 10 | Days 5 6 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER: 12. Name Chas Hammer
13. Birthplace Germany

MOTHER: 14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Geo Heim
(b) Address 2544 W Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-20-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Frnt Ave

18 (a) Funeral director Geo H. Kemphaus
(b) Address 5 N. N. Lyndhurst St

19 (a) FEB 18 1947 Huntington Registrar
(b) Date filed

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1947 at 6.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940 to 2/17 1947 and that I last saw her alive on 2/17 1947

Immediate cause of death: Cerebral Hemorrhage — Duration 2/13/47

Due to: Cardio-Vascular Disease & Hypertension — Duration 2 years.

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

28. Signature Elliot W. Johnson M.D. M. D.
Address 3432 Druid Park Ave Date signed

G48738 Certificate Dead Born 10998

BALTIMORE CITY HEALTH DEPARTMENT X V

# CERTIFICATE OF DEATH 159

G48738 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Fulkens & Caton Ave.
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 413 Ingleside Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Girl Freed

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-18-47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | 4 hr. min. |

9. Birthplace Catonsville, Md.
(Town, county and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Wilford L. Freed
13. Birthplace Virginia

MOTHER
14. Maiden Name Georgie Mae Bowers
15. Birthplace Md.

16 (a) Informant

(b) Address

17 (a) Burial (b) Date thereof Feb. 19, 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Providence Cem.
Location Glenelg Howard Co. Md.

18 (a) Funeral director Easton Home
(b) 1947 Ellicott City, Md.

19 (a) Thos. Worthington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 2-18 1947 at 4 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2-18 1947 to 2-18 1947, and that I last saw her alive on 2-18 1947.

Immediate cause of death — Premature Birth — Duration 6 hours

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature Jean A. Kochman M.D.
Address Ellicott City, Md. Date signed 2/18/47

X

Muller

G48739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G48739 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 347 Charles St
(c) Hospital or institution: Cambridge Apts
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltcity
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 347 Charles St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie Kinzer Muller

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Chas. Edw. Muller

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug-15-1861

8. AGE: Years 85 | Months 6 | Days 2 | If less than one day: hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name John Christopher Matthei
13. Birthplace Germany

MOTHER
14. Maiden Name Teresa Jaukeda
15. Birthplace France

16 (a) Informant Mrs. Wm C. Scott (niece)
(b) Address 811 St Georges Rd — 10.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 19-47 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge.
Location Pikesville.

18 (a) Funeral director Stewart Morgan Co.
(b) Address 108 W Mount Ave.
(Registered by) (Huntington Williams, M.D.)

FEB 18 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1947, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1936 to Feb 17 1942, and that I last saw he/she alive on 2/17 1942

Immediate cause of death: Cystic Sclerosis / Myocarditis — Duration: Final

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H H Heady M. D.
Address 1403 Parkard Date signed 2/18/42

VS 150

G48740

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13B

Registered No. G48740

CWK-107928

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 812 Whatcoat Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Carl Spicer

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14-1909

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 37 | 5 | 26 | hr. min. |

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Steve Spicer (D)
13. Birthplace ?
14. Maiden Name Ella ?
15. Birthplace West Indies

16 (a) Informant Records-Balto. City Hospitals
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19-47 (month) (day) (year)
(c) Cemetery or crematory Emanuel Heart Comm.
Location Baltimore, Md.

18 (a) Funeral director Hand Katie R. Williams
(b) Address 322 N. Schroeder St

19 FEB 18 1947 Registrar's signature Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

P

20. DATE OF DEATH February 10 1947, at 1:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 25 1947, to Feb. 10 1947, and that I last saw him alive on Feb. 10 1947.

| | Duration |
|---|---|
| Immediate cause of death Pulmonary Tuberculosis, Far-advanced | 1yr. |
| Due to | |
| Due to | |
| Other Conditions None | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. J. Hunt M.D.
Balt. City Hosp. Date signed 2-13-47

X

G48741

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

460

G48741 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Frederick
(c) City or town Myersville
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Albert Shank

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ada Shank

6 (c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): 1883

8. AGE: Years: 64 | Months | Days | If less than one day: hr. min.

9. Birthplace: Middletown, Frederick, Md.
(Town, county, and state)

10. Usual Occupation: Day Laborer

11. Industry or business

FATHER
12. Name: Carl Shank
13. Birthplace: Myersville, Md.

MOTHER
14. Maiden Name: Sarah Palmer
15. Birthplace: Myersville, Md

16 (a) Informant: Ed Shank
(b) Address: Myersville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-47 (month) (day) (year)
(c) Cemetery or crematory: Lutheran Cemetery
Location: Myersville, Md

18 (a) Funeral director: C. B. Hilliard Co.
(b) Address: Middletown, Md.

FEB 18 1947 (b) Registrar
(Date received by local registrar)
Huntington Hilliard, M.D.

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 2-18 1947, at 9:45 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2-15 1947 to 2-18 1947, and that I last saw him alive on 2-18 1947.

| | Duration |
|---|---|
| Immediate cause of death: Massive Pneumonia | 8 hrs. |
| Due to: Carcinoma of Esophagus | 2 yrs? |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23. Signature** John C. Morrison M. D.

Address Union Hosp. Date signed 2/18/47

X

G48742 MARYLAND STATE DEPARTMENT OF HEALTH G48742

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH 83a Reg. Dist. No.

**1. PLACE OF DEATH:**

County

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 hours

Hospital, institution, or street address where death occurred: 310 E North Ave

How long in hospital or institution? Removed to clinic

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State Penna County Dauphin

City or town Harrisburg (If outside city or town limits, write RURAL and give nearest town)

Street No. 1617 Thompson St. (If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** BERTHA E. REISINGER

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | MARRIED |

6.(b) Name of husband or wife Milton A. Reisinger

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Oct. 24 - 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 3 | 24 | hrs. min. |

9. Birthplace Eberlys Mills, Cumberland Co, Penna (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Retired

FATHER 12. Name ~~George E. Harburger~~ George Stoltzfus

13. Birthplace Stoltzfus, Penna.

MOTHER 14. Maiden name ~~Rebecca E. Harburger~~ Mary Nash

15. Birthplace Eberlys Mills Penna

16. Informant Mr Milton A Reisinger

Address 1617 Thompson St Harrisburg

17. Removal (Burial, cremation, or removal. Which?) Date thereof 2/15/47 (month) (day) (year)

Cemetery or crematory St Johns Cemetery

Location Camp Hill Pennsylvania

18. Funeral director John E Montanari

Address 3 W 3000 N Baltimore St

19. FEB 19 1947 (Date rec'd by registrar) Huntington Williams, M.J. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 1947, at 2 30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 08 1947, to Feb 18 1947

and that I last saw h[illegible] alive on Tuesday Feb 11 1947

Immediate cause of death Hypostatic Pneumonia — DURATION

Due to Hypertension

Due to Asthma

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry L Sinskey M.D. M. D. or other

Address 310 E North Ave Date signed 2/18/47

G48743

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46M

Registered No. G48743

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 60 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1331 Mosher St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Tongue, Irvin T.

3 (b) If veteran, name war WW 2

3 (c) Social Security Account No. ?

4. Sex M | 5. Color or race col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Eddie Belle Shuford Tongue

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) April 15, 1901

8. AGE: Years 45 | Months 10 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Anne Arundel Co. Md.
(Town, county, and state)

10. Usual Occupation Shipfitter

11. Industry or business

FATHER
12. Name Richard Tongue
13. Birthplace Anne Arundel Co. Md.

MOTHER
14. Maiden Name Bertie ?
15. Birthplace Anne Arundel Co. Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-20-47 (month) (day) (year)
Cemetery or Crematory Baltimore Nat. Cem.
Location Frederick Ave.

18 (a) Funeral director Charles R. Law
(b) Address 802 Mad. Ave.

19 (a) Date received by registrar FEB 19 1947 (b) Registrar Huntington, Williams, Jr.

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb. 18 19 47, at 11:50A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec. 20 1946, to Feb. 18 1947, and that I last saw him alive on Feb. 18 1947.

Immediate cause of death Metastatic Carcinoma, abdominal viscera — Duration UNKNOWN

Due to Other conditions, Peritoneal abscess — UNKNOWN

Due to Other Conditions Generalized peritonitis — UNKNOWN
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Of autopsy: As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23.** Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 2/18/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48744 BCH G56112 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 6 Registered No. G48744

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hours
(e) Length of stay in Baltimore (yrs., mos., or days) 5 months

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3413 Menlo Drive (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** David Lynn Rudo

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | S |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| — | 5 | 12 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Herbert Rudo
13. Birthplace Maryland

MOTHER 14. Maiden Name Ida Rena
15. Birthplace Maryland

16 (a) Informant Herbert Rudo
(b) Address 3413 Menlo Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19-47 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel
Location Southern ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1425 E Balto St

FEB 19 1947 (Date rec'd by registrar) (b) Registrar Huntington Williams, MD

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 18 1947 at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1200 Feb 18 1947 to Feb 18 1947 and that I last saw he alive on Feb 18 1947.

Immediate cause of death meningococcic septicemia — Duration 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Evan B Chambers M. D.
Address Union Memorial Hosp Date signed 2/18/47

VS 150

G48745

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

G48745
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Greenspring ave
(c) Hospital or institution: Levindale

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State N. J. (b) County
(c) City or town New York (If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 Walton ave N Y (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** LOUIS WINCOR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12-1905

8. AGE: Years 41 | Months 8 | Days 6 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name Herman
13. Birthplace Russia

MOTHER
14. Maiden Name Esther
15. Birthplace Russia

16 (a) Informant Esther Wincor
(b) Address 1414 Walton Ave N Y

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19-47 (month) (day) (year)

(c) Cemetery or crematory
Location New York City

18 (a) Funeral director Jack Lewis, Inc
(b) Address 1109 E Balto St

19 (a) FEB 19 1947 (Date rec'd by registrar) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2-18 1947, at 10 p M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-22 1945 to 2-18 1947 and that I last saw h[illegible] alive on 2-18 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | |
| Due to arteriosclerosis | |
| Due to | |
| Other Conditions Old hemiplegia Coronary thrombosis | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Vogel M. D.
Address Levindale Home Date signed 2-18-47

83a

G48746

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

937

Registered No. G48746

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4206 Rayman ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4206 Rayman ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Annie B. Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | widowed |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 10/11 | 18 | hr. min. |

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name William Caulk
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Mary Buckner
15. Birthplace Va

16 (a) Informant Mrs. Anna Schultz
(b) Address 4206 Rayman Ave

17 (a) Burial (b) Date thereof 2/21/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Road

18 (a) Funeral director Howard N. Blight Jr
(b) Address 4914 Belair Road

19 (a) Date rec'd by local reg. FEB 19 1947 (b) Registrar Huntington Williams M.D.

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb 18 1947, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to 2/18 1947 and that I last saw h[illegible] alive on 2/15 1947.

Immediate cause of death: Ch. Myocarditis. — Duration: 5 years

Due to: Arteriosclerosis

Due to: Hypertension

Other Conditions: 0

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: 0

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide 0
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. S. Hardesty M. D.
Address 4810 Belair Rd Date signed 2/15/47

VS 150

G48747
CWK-106564

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 937

G48747
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 15-
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 219 N. High Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Christian Taraldsen

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22-1893

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | 9 | 18 | hr. min. |

9. Birthplace Norway
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Christian Taraldsen
13. Birthplace Norway

MOTHER
14. Maiden Name Loretta Bjarkaas
15. Birthplace Norway

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 2/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location Belair Mill Road
18 (a) Funeral director J. E. Fahey & Sons
(b) Address 1319 Eight St.
19 (a) (b)
(Date rec'd by registrar) Registrar
FEB 19 1947
95 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 10 1947, at 10:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 25 1946 to Feb. 10 1947 and that I last saw h. alive on Feb. 10 1947

| Immediate cause of death | Duration |
|---|---|
| Coronary occlusion | |
| Due to arteriosclerosis | |
| Due to | |
| Other Conditions (1) Hypertension Cardiovascular disease (2) auricular fibrillation | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin C. Evans M. D.
Address Balto. City Hosp. Date signed Feb 17, 47

Hunting for Williams, M.D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48748
TN. 108173

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 13B

G48748
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 136 S. Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sam Kapala

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 1st. 1892

8. AGE: Years 54 | Months 4 | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace Illinois
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Thomas Kapala
13. Birthplace Illinois

MOTHER
14. Maiden Name Annie Galaranski
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 (month) 19 (day) 47 (year)
(c) Cemetery or crematory Sacred Heart Plan
Location Lorman Mill Road

18 (a) Funeral director D. J. Bailey Funeral Home
(b) Address 1301 Light St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS FEB 19 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9th 1947 19 ... at 10.05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 4th 1947 to Feb. 9th 1947, and that I last saw h... alive on Feb. 9th 1947.

Immediate cause of death
Pulmonary Tuberculosis — Duration +5 years

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. S. Slater
Address Baltimore City Hosp Date signed 14 Feb 47

X

G48749

BALTIMORE CITY HEALTH DEPARTMENT

G64346-6 CERTIFICATE OF DEATH 119a

Registered No. G48749

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Greene & Lombard St 4
(c) Hospital or institution:
University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 8 wks

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 744 W Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fanny Mae Johnson G64345

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Infant |

6 (b) Name of husband or wife Infant

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/24/46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 2 | 19 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles H Johnson
13. Birthplace Penn.

MOTHER
14. Maiden Name Ellen Jane
15. Birthplace W-Va.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo FEB 18 1947

18 (a) Funeral director Commissioner of Health
(b) Address

FEB 19 1947 (Date rec'd by Registrar) Harry J. Williams M.D.

VS 150 1939

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/13/ 1947, at 2P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-27 1947, to 2-13 1947, and that I last saw he[illegible] alive on 2-13 1947.

| Immediate cause of death | Duration |
|---|---|
| Malnutrition | |
| dehydration | |
| infection diarrhea | |
| Due to | |
| | |
| Due to | |
| | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy 2-13-47

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Y Mastenbrook M. D.
Address University Hosp Date signed 2/13/47

X

G48750

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48750
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secour Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State (b) County A.A. Co
(c) City or town Morris Hill
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | WIDOWED |

6 (b) Name of husband or wife Fannie Hall Smith
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) OCT 30 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 3 | 18 | hr. min. |

9. Birthplace Curtiss Bay, MD.
(Town, county, and state)

10. Usual Occupation FARMER
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace Curtiss Bay, MD

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace UNKNOWN

16 (a) Informant ALBERTA BERK
(b) Address 2308 MILLER AVE

17 (a) BURIAL (b) Date thereof 2/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL
Location ANNAPOLIS BLVD.

18 (a) Funeral director JOHN F. DENNY, INC
(b) Address 715 LIGHT ST.

19 (a) (b)
Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 17 1947, at 11 07 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

| Immediate cause of death | Duration |
|---|---|
| Pulmonary edema | 2 day |
| Due to Coronary Thrombosis | 2 day |
| Due to Arterio-sclerotic Heart disease | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E. Farber M. D.
Address Bon Secour Hosp. Date signed 2-17-47

Filed FEB 19 1947 Huntington Williams, M.D.

G48751

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G48751

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 626 S Wolfe St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Carl Graboswski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Paulina

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2/20/63

8. AGE: Years 83 84 | Months 11 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Gustav Grabowski
(b) Address 626 S. Wolfe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director Tyler & Lyles
(b) Address 403 S. Wolfe St.

19 (a) (Date rec'd by Registrar) FEB 19 1947 Registrar

VS 181

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 16 1947, at 11:00 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C. V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William F. Holzbach Medical Examiner
Date signed 16 Feb 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48752

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

937

G48752 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Reyna ave. & Dukeland St.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) —

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 Gwynns Falls Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs. Antonia Blaha

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Charles Blaha
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 18, 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 4 | 0 | hr. min. |

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Staatny
13. Birthplace —

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mr. Arthur C. Blaha
(b) Address 1710 Gwynns Falls Pkwy.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 18 47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 19 1947 (Date received by registrar) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 18, 1947 at 7-15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 18, 1947 to Feb. 18, 1947 and that I last saw h[illegible] alive on Feb. 18, 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardio-respiratory failure | |
| Due to Cerebral hemorrhage | |
| Due to Arteriosclerotic cardiovascular disease | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leon Toby M.D.
Address West Balto. Gen. Hosp. Date signed 2/18/47 M. D.

VS 150

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48753
CWK-97699

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 1937

Registered G48753

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 2- 12-
(e) Length of stay in Baltimore (yrs., mos., or days) Not Known

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 Linden Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** JAMES THOMAS KENNEDY

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widower |

6 (b) Name of husband or wife: Sula M. Kennedy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1861

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 85 | 7 | 24 | hr. min. |

9. Birthplace Staunton, Virginia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Thomas Kennedy
13. Birthplace Ireland

MOTHER
14. Maiden Name Marian Sophia Lawerence
15. Birthplace Ireland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 19 1947 (b) Registrar Huntington Williams M.D.

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** February 17 19 47 at 7:30 M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec. 5 19 45 to Feb. 17 19 47 and that I last saw him alive on Feb. 17 19 47.

| Immediate cause of death | Duration |
|---|---|
| Heart Failure | 2 yrs |
| Due to Arteriosclerosis | 15 yrs |
| Heart Disease | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Yes No Post

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Clabaugh Jr. M. D.
Address Balt. City Hospitals Date signed 2/17/47

X

G48754

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G48754 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** Ira Ingledue

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | white | widowed |

6 (b) Name of husband or wife Lilian Meyers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 3, 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 11 | 14 | hr. min. |

9. Birthplace Missouri (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Harvey Ingledue
13. Birthplace England

MOTHER
14. Maiden Name Martha Gardner
15. Birthplace

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 20, 1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Pete Wendrow
(b) Address 900 E. Baltimore St

19 (a) (Signature) Feb 19 1947 Registrar Registered

VS 3

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 17 1947, at 11:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1947, to Feb 17 1947, and that I last saw him alive on Feb 17 1947.

| Immediate cause of death | Duration |
|---|---|
| Edema Lungs | 1 day |
| Due to Chronic Myocarditis | 3 yrs |
| Due to | |
| Other Conditions Arterio-Sclerosis | 5 yrs |

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E North Ave Date signed 2/18/47

G48755

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 77c

Registered No. G48755

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 Boyd St
(If no street give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Maurice James Ritter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 19, 1912

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 34 33 | 1 | 30 29 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Hustler

11. Industry or business Junk

FATHER
12. Name Ernest H. Ritter
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Bessie E Bowers
15. Birthplace Baltimore Md

16 (a) Informant Bessie E. Ritter
(b) Address 4002 Belvidere Ave

17 (a) Burial (b) Date thereof 2/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Baltimore, Md.

18 (a) Funeral director John Lowman & Co
(b) Address 901 W. Fayette St

19 (a) FEB 19 1947 (b) Huntington Williams
(Date rec'd by registrar)

VS 191

**MEDICAL CERTIFICATION** 25

**20. DATE OF DEATH** February 18, 1947, at 12 A.M

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH acute alcoholism

Due to

Other Conditions acute pulmonary edema acute dilatation of heart
(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

**23.** Signature Howard J. Weaver, M.D.
Medical Examiner.
Date signed 2-18-47

X

G48756

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 170c

G48756 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dor
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 N. Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Herbert Bennett

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Single |

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | - | 11 | hr. min. |

9. Birthplace Balto. Co. Md.
(town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name George Bennett
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Ruth Thompson
15. Birthplace Balto. Co. Md.

16 (a) Informant Alonzo Bennett
(b) Address 2312 McCulloh St.

17 (a) Burial (b) Date thereof Feb. 19, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Lukes
Location Reisterstown Md

18 (a) Funeral director Chas. H. Holland
(b) Address 1603 Druid Hill Ave

19 (a) FEB 19 1947 (b) Huntington Williams M.D.
(Date rec'd by Registrar) (Registrar)

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 14 1947, at 6 00 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured heart
Lacerations of the liver

Due to

Other Conditions Multiple fractures

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 14/3

(a) Date of injury 2-14-47 at 6:15 P M.
(b) Where did injury occur? McCulloh St. & Preston
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Pedestrian Struck by auto

23. Signature Howard J. Woodson M.D.
Medical Examiner.
Date signed 2-15-47

G48757

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 111c

G48757 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division ST
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 McCulloh ST
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) **FULL NAME** Thaddeus W. Copeland

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | Negro | W |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26, 1855

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 91 92 | 8 | 23 | hr. min. |

9. Birthplace Illinois (Town, county, and state)
10. Usual Occupation Upholsterer
11. Industry or business

MOTHER / FATHER
12. Name Unknown
13. Birthplace
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Bertha Pegles
(b) Address 1513 McCulloh St.

17 (a) Burial (b) Date thereof Feb. 20, 1947
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Laura A. Holland
(b) Address 1601 Druid Hill Ave.

FEB 19 1947 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 18 1947, at 2.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-3 1946, to 2-18 1947, and that I last saw him alive on 2-18 1947

Immediate cause of death Hypostatic pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. R. L. Jackson / Fontette M. D.
Address 600 N Arlington Ave Date signed 2-18-47

MARGIN RESERVED FOR INDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48758

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 136

G48758 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1433 Jefferson St
(c) Hospital or institution: 51

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1433 Jefferson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viola White 730 Pm

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1897

8. AGE: Years 49 50 Months 8 6 Days 10 6 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Albert White
13. Birthplace Balto, Md

MOTHER
14. Maiden Name Nettie Cooper
15. Birthplace Balto Md

16 (a) Informant Mrs Ada White
(b) Address 1433 Jefferson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-20-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Baltimore, Md.

18 (a) Funeral director Miss Ida Bailey
(b) Address 1421 E. Jefferson St. Baltimore, Md.

19 (a) (Signature of local registrar) (b) Registrar

FEB 19 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1947, at 730 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1947 to Feb 16 1947, and that I last saw h alive on Feb 15 1947.

Immediate cause of death (a) Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Edward Fisher M. D.
1421 E Monument St Date signed Feb 17 1947

Feb 17 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48759

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13B

G48759 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 908 N. Gay
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10'
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 908 N. Gay
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edmund Brown
3 (b) If veteran, name war
3 (c) Social Security Account No. 214-03-0857
4. Sex Male
5. Color or race Col
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 29, 1888
8. AGE: Years 58 Months 7 Days 24 If less than one day hr. min.
9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Night watchman
11. Industry or business
FATHER 12. Name Benj Brown
13. Birthplace Balto Md
MOTHER 14. Maiden Name Amanda Scott
15. Birthplace Baltimore, Md
16 (a) Informant Elizabeth Lee
(b) Address 1516 E Madison St
17 (a) Burial (b) Date thereof 2-22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Baltimore, Md.
18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 E Jefferson St.
19 (a) (b) Registrar
(Date rec'd by registrar)
FEB 19 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 18 1947, at 4 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 27 1947 to Feb 18 1947. and that I last saw him alive on Feb 17 1947.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Tuberculosis | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Edward F. Fisher
Address 2 E. Monument Date signed Feb 18 47

VS 150

X

G48760

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

G48760 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1367 Calhoun St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14yr

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1367 N. Calhoun (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Gardner Moses

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: M
6 (b) Name of husband or wife: Nathaniel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/1/1900

8. AGE: Years 47 | Months 1 | Days 15 | If less than one day: hr. min.

9. Birthplace Sparks, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John H. Gardner
13. Birthplace Md

MOTHER
14. Maiden Name Amy Johnson
15. Birthplace Md.

16 (a) Informant Florence Bundy
(b) Address 1367 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/47 (month) (day) (year)
(c) Cemetery or crematory Sparks
Location Sparks Md

18 (a) Funeral director Leo. S. Nelson
(b) Address 1303 Presstman St

19 (a) 2/18 19 47 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 16 Feb. 1947, at 1.30 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 Feb 1947 to 16th 1947, and that I last saw h[illegible] alive on 15 Feb 1947

Immediate cause of death: Cerebral Hemorrhage — Duration: 8 Days
Due to: Uremia & Chronic
Due to: Chr. Nephritis.
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature W S Pott M.D.
Address 1506 Cathedral St. Date signed 18 Feb.

VS 150

G48761 BCH G67154 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 119a G48761 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3816 Edmondson Road
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 52 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 52 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3816 Edmondson Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Davis Rehmeyer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1946

8. AGE: Years | Months: 1 mo. | Days: 22 | If less than one day: 20 hr. min.

9. Birthplace Baltimore, Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wilmer Rehmeyer
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Vanda Sullivan
15. Birthplace Maryland

16 (a) Informant Wilmer Rehmeyer
(b) Address 3816 Edmondson Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 20/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive
Location Randallstown, Md

18 (a) Funeral director C. Hennegan & Sons
(b) Address 3615-17 Edmondson Ave.

19 (a) FEB 19 1947 (Date received by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 18 1947, at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2 1947 to Feb. 18 1947, and that I last saw him alive on Feb. 18 1947.

| Immediate cause of death | Duration |
|---|---|
| Cachexia | |
| Due to Dehydration | |
| Due to Diarrhea | |
| Other Conditions Prematurity | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Burkhart M.D.
Address Md. Gen. Hospital Date signed Feb 18, '47

VS 130

G48762 BC# G67153-4

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1190

G48762

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3816 Edmondson Road
(c) Hospital or institution Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 53d.
(e) Length of stay in Baltimore (yrs., mos., or days) 53 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3816 Edmondson Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Wilmer Rehmeyer

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 1 | 23 | hr. min. |

9. Birthplace Baltimore, Baltimore Maryland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Wilmer Rehmeyer
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Vanna Sullivan
15. Birthplace Maryland

16 (a) Informant Wilmer Rehmeyer
(b) Address 3816 Edmondson Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 22 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Rockville Town, Md.

18 (a) Funeral director Edmondson & Donovan
(b) Address 3616-17 Edmondson Ave.

19 (a) (Date received by registrar) (b) Registrar

FEB 19 1947

Huntington for Hillegeist

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** February 19 1947, 6:25 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Feb. 2 1947 to Feb. 19 1947, and that I last saw him alive on Feb. 19 1947.

| Immediate cause of death | Duration |
|---|---|
| Sepsis | |
| Due to Baby Diarrhea | |
| Due to Diarrhea | |
| Other Conditions Prematurity | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Burtnett M. D.
Address Maryland Gen'l Hosp. Date signed Feb. 19, 1947

X

G48763

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH √131a

Registered No. G48763

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2842 Lake Ave.
(c) Hospital or institution: q

(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2842 Lake Ave. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

**3 (a) FULL NAME** Henry J. Powell

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife Catherine Sauters
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 5 | 21 | hr. min. |

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John
13. Birthplace Wales

MOTHER
14. Maiden Name Hannah Charles
15. Birthplace Wales

16 (a) Informant Catherine Powell
(b) Address 2842 Lake Ave.

17 (a) Burial (b) Date thereof 2/21/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) 2/19/47 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH Feb. 18 1947, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15 1947 to Feb. 18 1947 and that I last saw h in alive on Feb. 18 1947

| Immediate cause of death | Duration |
|---|---|
| Coronary Occlusion | 1 day |
| Due to Cardio-renal-vascular Disease | 2 yrs. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature J. W. Wilson M. D.
Address 617 W. 40th St. Date signed 2/19/47

VS-150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

30E

Reg. G48764

~~G48764~~

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 712 S. Bethel St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Caption or Capton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1888

8. AGE: Years 58 | Months 11 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Penna.
(Town, county, and state)

10. Usual Occupation Fruit Stand

11. Industry or business Self

FATHER
12. Name Tonia Caption
13. Birthplace Ohio

MOTHER
14. Maiden Name Camelia
15. Birthplace Ohio

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 19-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Frank Della Vecchia
(b) Address 52 N. Wesley Ave

19 (a) ... (b) ... Registrar

FEB 19 1947

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION A. M.

20. DATE OF DEATH Feb. 16 19 47, at 11:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19 19 47 to Feb. 16 19 47, and that I last saw him alive on Feb. 16 19 47.

Immediate cause of death: Syphilitic Cardiovascular disease — Duration: 20 yrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. R. McGuinness M. D.

Address Baltimore City Hosp. Date signed 2-20-47

X

G48765

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 134a

G48765 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 210 N. Calhoun
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1717 E. Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Rose Offidani

3 (b) If veteran, name war: No
3 (c) Social Security Account No. No

4. Sex: Female | 5. Color or race: W. | 6 (a) Single, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband ~~or wife~~: John Offidani

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29 1898

8. AGE: Years 48 | Months 4 | Days 20 | If less than one day: hr. min. 19

9. Birthplace Italy (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER — 12. Name Agostino Offidani
13. Birthplace Italy

MOTHER — 14. Maiden Name Rosa
15. Birthplace Italy

16 (a) Informant Pete Offidani Son
(b) Address 1717 E. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-47 (month, day, year)
(c) Cemetery or crematory Holly Cemetery
Location Belair Road

18 (a) Funeral director Frank Bello Hoe
(b) Address 52 N. Morley St

19 (a) FEB 19 1947 (Date rec'd by registrar) Huntington Williams

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/18 1947; at 7.04 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-16 1946 to 2/18 1947, and that I last saw her alive on 2/18 1947.

Immediate cause of death Uremia — Duration 3 days

Due to Perinephritic abscess RT; Renal Calculi, BILATERAL — 3 mos

Due to

Other Conditions RHEUMATIC CARDIO-VASCULAR DISEASE — Several Yrs.
(Include pregnancy within 3 months of death)

Date of operation 12/19/46

Major findings of operation: PERINEPHRITIC ABSCESS RT.

of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marston Bratz M. D.
Address Franklin Square Hosp. Date signed 2/18/47

G48766 Birth Certificate B-71042

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1606

G48766 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: Sixth Beds. Gen'l Hosp. 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) L.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. (24).
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 S. Fagley St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Emory Clark. II

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | S. |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 18 Feb 47.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | 2 hr. min. |

9. Birthplace S.B.C.N.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Emory Clark I
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Dorothy Catherine Swingle
15. Birthplace Balto. Md.

16 (a) Informant father
(b) Address 901 S. Fagley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 19-47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Gor Ritchie Highway
18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St
(c) Date rec'd by registrar FEB 19 1947 Huntington Williams Hgts

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 18 Feb 1947, at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 18 Feb 1947 to 18 Feb 1947, and that I last saw h.l.yrs. alive on 18 Feb 1947.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Pre-viable infant (23 weeks) 1 lb. | |
| Due to Pre-mature rupture membranes | |
| Other Conditions Pre-mat. labor. | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Cohen
Address Sixth Beds Gen'l Hosp Date signed 18 Feb 47 M D

VS 150

X

G48767

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

G48767 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 549 W. Hoffman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

17

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 549 W. Hoffman St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** THOMAS H. WILLIAMS

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | C | Widowed |

6 (b) Name of husband or wife Cora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/1/1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 6 | 14 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name Robt. J. Williams
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Marie Hardy
15. Birthplace Balto. Md.

16 (a) Informant Mary Stokes (Sister)
(b) Address 549 W. Hoffman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) FEB 19 1947 (Date received by registrar) (b) Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 15, 1947, at 11:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1947 to Feb 15 1947 and that I last saw h[illegible] alive on Feb 15 1947.

Immediate cause of death Coronary Thrombosis
Renal Disease

| Duration |
|---|
| |

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. Stenhouse M. D.
Address 1202 Dartmouth Date signed 2-18-47

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48768

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V 170 c

G48768 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 Hunter Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Mary Low White

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | |

6 (b) Name of husband or wife Roland White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1927

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 20 | | | hr. min. |

9. Birthplace Alabama (Town, county, and state)
10. Usual Occupation Factory Worker
11. Industry or business

FATHER
12. Name Eddie Snead
13. Birthplace Alabama

MOTHER
14. Maiden Name Edith Snead
15. Birthplace Alabama

16 (a) Informant Roland White
(b) Address 1309 Hunter Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 21, 1947 (month) (day) (year)
(c) Cemetery or crematory Dothan
Location Houston Co. Alabama

18 (a) Funeral director Elvey O. Wilson
(b) Address 1000 Bentley Ave

19 (a) FEB 19 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

**MEDICAL CERTIFICATION** 16 EH

20. DATE OF DEATH February (22) 1947, at 8:15 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident (probable) ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull; Intra-cranial hemorrhage; Laceration of the scalp.
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 25/6.
(a) Date of injury 2-16-47 at A.M.
(b) Where did injury occur? Found on Saloon front of 3317 Ann St.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Struck by auto.? Police opinion

23. Signature Howard J. Mullen M.D. Medical Examiner.
Date signed 2-17-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48769

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46E

Registered No. G48769

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days.
(e) Length of stay in Baltimore (yrs., mos., or days) lifelong years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 735 E 36th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME WILLIAM BROWN TODD

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife BESSIE WILKINS TODD
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB 4 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 0 | 14 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Insurance Salesman
11. Industry or business

FATHER 12. Name GEORGE TODD
13. Birthplace MARYLAND

MOTHER 14. Maiden Name ANNIE BARTON
15. Birthplace Maryland

16 (a) Informant wife
(b) Address 735 E 36th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Williams & Dee
(b) Address 1217 N Eutaw

FEB 19 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 18 1947 at 7.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 11 1947 to Feb 18 1947.
and that I last saw h[illegible] alive on Feb 18 1947.

| Immediate cause of death | Duration |
|---|---|
| Uremia | Unknown |
| Due to Carcinoma testis | |
| Due to Carcinoma descending colon | one month |

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Feb 11, 1947
Major findings of operation: Mass in descending colon
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph C. Pratt M. D.
Address Union Memorial Hosp Date signed Feb 19, 1947

VS 150

X

G18770

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G18770 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 507 Millington Avenue
(c) Hospital or institution: 7D
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 507 Millington Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** IDA MAY REPP

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | white | Widowed |

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 5 | 7 | hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Warren Tyson Powers
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Dasch
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Jessie Gregory
(b) Address 507 Millington Avenue

17 (a) burial (b) Date thereof 2/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) Date received by Registrar FEB 19 1947 (b) Huntington Williams Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/17 1947, at 1 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 1947, to 2/17 1947 and that I last saw h alive on 2/17 1947.

Immediate cause of death Arterio — sclerotic cardio vascular disease — Duration 6 mos.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Welles M. D.
Address 2030 Wilkens Date 2/17/47

VS 150

an X

G18771 Barnes Dr

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 927

G18771 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5208 Cuthbert Ave.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5208 Cuthbert Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles Roberts, Sr.

3 (b) If veteran, name war: -

3 (c) Social Security Account No. -

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife: Fannie
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) March 8, 1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 11 | 10 | hr. min. |

9. Birthplace: Scotland (Town, county, and state)
10. Usual Occupation: Research Chemist
11. Industry or business: Fla vor Extract Co.

FATHER
12. Name: Unknown
13. Birthplace: Scotland

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Scotland

16 (a) Informant: Mrs. Fannie Roberts
(b) Address: 810 N. Appleton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 20, (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Baltimore, Maryland

18 (a) Funeral director: Wm. Cook, Inc.
(b) Address: 1217 St. Paul St.

19 (Date received by registrar) FEB 19 19 47 Huntington for Wilkins, M.D. Registrar

**MEDICAL CERTIFICATION** A.

20. DATE OF DEATH Feb. 18 19 47 at 12:30 M.

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 19[illegible] to Feb 18 1947, and that I last saw h[illegible] alive on [illegible] 19[illegible].

| Immediate cause of death | Duration |
|---|---|
| Uraemia Hepatic Disease | 3 yrs |
| Due to | |
| Due to | |
| Other Conditions: High Blood Pressure Coronary Disease (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. C. Heaver M. D.
Address 3900 Clarenden Date signed Feb 19 1947

VS 150

G18772

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G18772 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Siani Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Middle River Balto. Co.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 Contact Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** AGNES MAY DUDLEY

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Winfield W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: About 65 | Months | Days | If less than one day: hr. min.

9. Birthplace: Alton, Illinois (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Robert Graham
13. Birthplace: Scotland

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Illinois

16 (a) Informant: Winfield W. Dudley
(b) Address: 3 Contact Court, Middle River

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb. 19, 1947 (month) (day) (year)
(c) Cemetery or crematory: Terra Haute
Location: Terra Haute, Ind.

18 (a) Funeral director: William Cook, Inc.
(b) Address: 1217 St. Paul Street

19 (Date received by Registrar) FEB 19 1947 (b) Huntington Williams, M.D. Registrar

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1947, at 12:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/12 1947 to 2/19 1947 and that I last saw h[illegible] alive on 2/17 1947.

| Immediate cause of death | Duration |
|---|---|
| C.V. Accident | |
| Due to Hypostatic con (?) C.N.S. Lues (?) | |
| Due to | |
| Other Conditions (Include pregnancy within 3 months of death) 1) Bilateral pyelonephritis 2) Hypostatic Pneumonia 3) Arteriosclerosis | |

Date of operation 4/Hypostatic Pneumonia
Major findings of operation:
of autopsy: as above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address [illegible] Date signed 2/19/47

X

G48773

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G48773

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 338 E 25th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 338 E 25th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah A Brown

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Joseph A. Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 3. 1879

8. AGE: Years 67 | Months 4 | Days 14 | If less than one day hr. min.

9. Birthplace Annapolis Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Truman
13. Birthplace Maryland

MOTHER
14. Maiden Name Josephine Foreman
15. Birthplace Md

16 (a) Informant Joseph A Brown
(b) Address 338 E 25th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/47 (month) (day) (year)

(c) Cemetery or crematory Woodland Park
Location Baltimore Co Md

18 (a) Funeral director Wilson Funeral Home
(b) Address 2400 Greenmount Ave Balto Md

19 (a) (Date received by Registrar) (b) Registrar

FEB 19 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 17 1947, at 2:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 14th. 47 to Feb. 17th. 47. and that I last saw her alive on Feb. 12, 1947.

Immediate cause of death Coronary Thrombosis — Duration 5 days

Due to Arteriosclerosis — unknown

Due to ---

Other Conditions ---

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jas. W. Hungerford M.D.
Address 401 E. 25th. St. Date signed 2/19/47.

Howard J. Weaver, M.D. X

G48774 BALTIMORE CITY HEALTH DEPARTMENT G48774
CERTIFICATE OF DEATH 50 Registered No.

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2026 W. Fayette St.
(c) Hospital or institution: Bon. Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 616 S. Ellwood Av. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marie Jenkins
3 (b) If veteran, name war —
3 (c) Social Security Account No.
4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 25-1896
8. AGE: Years 50 | Months 3 | Days 22 | If less than one day hr. min.
9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Hemdgst Bros. Co.
FATHER 12. Name Wm. M. Jenkins
13. Birthplace Balto.
MOTHER 14. Maiden Name Rose Criswell
15. Birthplace Balto.
16 (a) Informant Edna M. Jenkins
(b) Address 616 S. Ellwood
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave & Rt.
18 (a) Funeral director John A. McJan
(b) Address 3000 E. Balto. St.
19 (a) FEB 19 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**
20. DATE OF DEATH 2/18 1947 at 10 30 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 6/5 1946 to 2/18 1947 and that I last saw h[illegible] alive on 2/18 1947
Immediate cause of death Cardiac Failure — Duration 3
Due to Metastatic Carcinoma — 1
Due to Carcinoma Breast, Left
Other Conditions Retroperitoneal Fractures R[illegible] Femur
(Include pregnancy within 3 months of death)
Date of operation 1944
Major findings of operation: Carcinoma breast
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Catherine E. Jones M. D.
Address Bon Secours Hosp. Date signed 2/18/47

VS 150

G48775

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 194a

G48775

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3201 Rosedale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John D Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Emma L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21-1885

8. AGE: Years 62 | Months - | Days 27 | If less than one day hr. min.

9. Birthplace Alabama Lowndes Co.
(Town, county and state)

10. Usual Occupation Civil Engineer

11. Industry or business

FATHER
12. Name Nathan W. Davis
13. Birthplace Alabama

MOTHER
14. Maiden Name Christine McLemore
15. Birthplace Alabama

16 (a) Informant Emma L. Davis
(b) Address 3201 Rosedale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/47 (month) (day) (year)
(c) Cemetery or crematory Greenlawn Park
Location Gaylor Ave

18 (a) Funeral director John A. Meehan
(b) Address 4201 Greenmount Ave

19 (a) 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1947, at M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Reifsnider M.D.
Date signed Feb 18, 1947 Medical Examiner

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 191

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48776

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G48776

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 440 E. Fort ave
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 440 E Fort ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Carrie Irene Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Divorced |

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 6-1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 1 | 10 | hr. min. |

9. Birthplace Carroll Co Md
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business —

FATHER
12. Name Isaac Smith
13. Birthplace Md

MOTHER
14. Maiden Name Elena C Null
15. Birthplace Md

16 (a) Informant Mrs James A Null
(b) Address 440 E Fort ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/47 (month) (day) (year)
(c) Cemetery or crematory Winters Cemetery
Location New Windsor Md

18 (a) Funeral director Geo L. Beyer Jr
(b) Address 1512 Holliday St

19 (a) (Signature of registrar) (b) Huntington Williams, Registrar

FEB 19 1947

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb. 16 1947, at 10 P.M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1947 to Feb 16 1947, and that I last saw deceased alive on Feb 15 1947.

| Immediate cause of death | Duration |
|---|---|
| Terminal Insufficiency | |
| Due to — | |
| Due to | |
| Other conditions Arteriosclerosis Hypertension | |

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operations —
of autopsy —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature John C Schenuch M. D.
Address 1337 S. Clarke St Date signed 2/18/47

X

G48777

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G48777 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 210 East St
(c) Hospital or institution: 5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 East St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Kilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Morris Kilson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 22nd 1868

8. AGE: Years 78 | Months 5 | Days 25 | If less than one day hr. min.

9. Birthplace Balto, Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name ? Fletcher

13. Birthplace Md

MOTHER 14. Maiden Name Harriett

15. Birthplace Md

16 (a) Informant Cecelia Murray Millspaugh

(b) Address 210 East St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 19th 1947 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location W. B. Co. Md

18 (a) Funeral director Bafaro-Magaziner-Wright

(b) Address 725 Pulaski St

19 (a) (Date received by registrar) FEB 19 1947 (b) Registrar, M. D.

V3 153

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb. 16th 1947 at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to Feb 1947. and that I last saw her alive on 12th Feb 1947.

| | Duration |
|---|---|
| Immediate cause of death Cardiac failure, | |
| Due to Hypertension, | |
| Due to Arteriosclerosis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Morris A. Drury M. D.

Address 118 Pisquid St Date signed 2/19/47

X

G48778
AB-108497

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48778
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19hrs-15min
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4318 N. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Oberg.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widowed |

6 (b) Name of husband or wife John D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23- 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 3 | 25 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Joseph Truesch
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 2/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.
18 (a) Funeral director John J. Connelly
(b) Address 418 Eastern Ave.-Local
19 (a) (b)
(Date rec'd by Registrar) Registrar

FEB 19 1947
VS 150

Huntington Williams, Md

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1947, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-15 1947 to 2-16 1947, and that I last saw h.er alive on 2-16 1947.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary tuberculosis | 1 mo. |
| Due to Chronic Alcoholism | 20 yrs |
| Due to Hepatic cirrhosis | 10 yrs |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: no autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature L. R. Huffman M. D.
Address Baltimore City Hosp. Date signed 17 Feb 47.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48779 ✓ Registered No. G48779

162 B

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 617 N. Mount St
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 N. Mount St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jane Fowler

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | widow |

6 (b) Name of husband or wife Dennis Fowler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 70 | | | hr. min. |

9. Birthplace Prince George Co. Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

| | |
|---|---|
| FATHER | 12. Name John Holland |
| | 13. Birthplace Md |
| MOTHER | 14. Maiden Name Ellen |
| | 15. Birthplace Md |

16 (a) Informant William Fowler
(b) Address 531 Lamburgland

17 (a) Burial (b) Date thereof Feb. 18, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 3229 W. Schroeder St

19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 19 1947 Livingston Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 1947, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 7 1947 to Feb 16 1947 and that I last saw her alive on Jan. 29 1947.

| Immediate cause of death | Duration |
|---|---|
| (a) Cardiac Failure | |
| Due to Old age | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Douglas Shepperd M. D.
Address 604 N. Dulaney Ave. Date signed 2/19/47

X

G48780

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48B

Registered No. G18780

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County ~~Baltimore~~
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1522 Boyle St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MILDRED WHEELCHEL

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEM | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Wayne Whelchel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1 - 25 - 07

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 40 | 0 | 23 | hr. min. |

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Frank Eiser

13. Birthplace Baltimore

MOTHER 14. Maiden Name Florence Ryan

15. Birthplace Baltimore

16 (a) Informant Charles J. Eiser

(b) Address 3415 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 20, 1947 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location 4300 Old Frederick Rd

18 (a) Funeral director Henry H. Wilhelm

(b) Address 4101 Edmondson Ave

19 (a) F B I 3 1947 (b) Washington Wilhelm Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 17 1947, at 11:5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h[illegible] alive on 2 - 17 1947.

| Immediate cause of death | Duration |
|---|---|
| | |
| Due to Cachexia | |
| Due to Generalized carcinomatosis. | over |
| Other Conditions (Cancer) | |

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: widespread Ca & abdomen.

**PHYSICIAN**
Underline the cause to which death should be charged statis-

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Geo. H. Maxwell M. D.

Address Md. Gen'l Hosp. Date signed 2 - 18 - 47

Maxwell - X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48781

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

126

G48781 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Nutkeeno + Caton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Howard
(c) City or town Elkridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5828 Victoria Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William R. Donohue
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Mabel L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1892

8. AGE: Years 54 | Months 8 | Days 27 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Local Worker
11. Industry or business Catholic Charities

FATHER
12. Name James F Donohue
13. Birthplace Ireland

MOTHER
14. Maiden Name Laura B Ryan
15. Birthplace Baltimore Md

16 (a) Informant Mrs Mabel L Donohue
(b) Address 5828 Victoria ave Elkridge

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 21/1947 (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Henry H Wyatt
(b) Address 4101 Edmondson ave

19 (a) Date filed by registrar (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-18 1947 at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-17 1947 to 2-18 1947 and that I last saw h/ he alive on 2/18 1947.

| Immediate cause of death | Duration |
|---|---|
| Inanition | |
| Duodenal Fistula | |
| Due to Constriction Common Bile Duct | |
| Due to Cholecystectomy | |
| Other Conditions Cholelithiasis | |

(Include pregnancy within 3 months of death)
Date of operation 15 Jan 47 & 30 Jan 47
Major findings of operation: Cholelithiasis & Constriction Common Bile Duct
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William E. McGrath M. D.
Address St Agnes Hosp Date signed 2/20/47

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. G48782

TB. 138191 G48782 BCH G64548

# CERTIFICATE OF DEATH

107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anita Ruth Poplaski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15th 1946

8. AGE: Years | Months: 6 | Days: 2 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Anthony Poplaski
13. Birthplace Pa.

MOTHER
14. Maiden Name Helen Hare
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records )

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 21 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director Henry A Wetzke
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

FEB 19 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17th 1947, at 7.43 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15th 1947, to Feb. 17 1947, and that I last saw her alive on Feb. 17 1947.

| | Duration |
|---|---|
| Immediate cause of death: Bronchopneumonia | 2 wks |
| Due to: Cerebral Damage due to Hyperthermia | 5 days |
| Due to: | |
| Other Conditions: Acidosis, Dehydration | 5 days |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julian P. Griffin M. D.
Address Balt City Hosp Date signed Feb 17 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G48783 B# G69914 BALTIMORE CITY HEALTH DEPARTMENT 161a G48783

# CERTIFICATE OF DEATH

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1703 Dukeland St.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 Dukeland St., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Catherine Agnes Taylor

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| --- | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | W. | Single |

6 (b) Name of husband or wife ----
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 10 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph S. Taylor
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Hewitt
15. Birthplace Baltimore, Md.

16 (a) Informant Joseph S. Taylor
(b) Address 1703 Dukeland St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-20-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave.

(c) Date received by registrar FEB 19 1947 Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 18, 1947 at 7.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7 47 to Feb. 18 47, and that I last saw her alive on Feb. 18, 1947.

Immediate cause of death — Duration

Atelectasis — 10 Days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. K. Nelson M.D.
Address 3207 W. North Ave. Date signed 2/19/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G48784

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

180

G48784

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore C.T. (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 N. Spring St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Robert Ruffin

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-4120

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1848

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 49 | | | hr. min. |

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Sezer Ruffin
13. Birthplace Va

MOTHER 14. Maiden Name Hester Watkins
15. Birthplace Va.

16 (a) Informant Henry Ruffin
(b) Address 2 W. Eldy St Richmond Va

17 (a) Burial (b) Date thereof (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Zion A.M.E. Church
Location Shannondale Va

18 (a) Funeral director Robert E. Williams
(b) Address 515 McElderry St

19 (a) (b) (Date rec'd by Registrar) Registrar

FEB 19 1947

VS 151

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 2/15 1947, at 0730 M

**21.** I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH 1st - 2nd - 3rd degree burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☑ or contributing ☐ cause of death fill in the following:
(a) Date of injury 2/15/47 at about 10 P 12 M.
(b) Where did injury occur? 905 N. Spring St
Did injury occur at home, on farm, industrial place, in public place? At Home While at work? No
(d) Means of injury Accidental fire at home

**23.** Signature C. J. Lubenske M.D.
Medical Examiner.
Date signed 2/16/1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48785
509928.

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

X ✓ 50

G48785
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State D. C. (b) County
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1736 Columbia Road N.W.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mabel O'Neal.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Thomas W. O'Neal |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-20-06.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 40 | 5 | 29 | hr. min. |

9. Birthplace Florence S. C.
(Town, county, and state)

10. Usual Occupation Bookbinder

11. Industry or business Sea Shore Music Co.

FATHER
12. Name R. B. Newlin
13. Birthplace N. C.

MOTHER
14. Maiden Name Pearl Moore
15. Birthplace N. C.

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 2/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Mount Olivet Cem. Burlington
Location Burl. Co. N.J.

18 (a) Funeral director W. J. Fishmer & Son
(b) Address North Ave. & Baker Md.

19 (a) FEB 20 1947 (b) Huntington & Williams Md.
(Signature of registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 19. 1947, at 7.51 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 13. 1947 to Feb 19 1947 and that I last saw her alive on Feb 19 1947.

| | Duration |
|---|---|
| Immediate cause of death Epitheliomatous Carcinomatosis | 9 mos |
| Due to Metastases from Carcinoma of breast (Left) | |
| Due to | |
| Other Conditions | |

(Include pregnancy within three months of death)

Date of operation 6/17/46

Major findings of operation: Carcinoma breast with metastases

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard C. Clay M. D.

Address Johns Hopkins Hosp. Date signed 2/19/47

X

G48786
TN. 88967

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 13B

Registered No. G18786

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-7-6
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Francis Lindsey

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | 194-09-7580 |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Elizabeth R.
6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) Aug. 28th 1916

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 30 | 5 | 21 | hr. min. |

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Shipfitter
11. Industry or business

FATHER
12. Name William George Lindsay
13. Birthplace Pa.

MOTHER
14. Maiden Name Olive O'Conner
15. Birthplace Pa.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/47 (month) (day) (year)
(c) Cemetery or crematory Slippery Rock Pa.
Location Slippery Rock Pa.

18 (a) Funeral director Henry Sander & Sons
(b) Address 1349 E. North Ave.

FEB 20 1947 (Registered by registrar) Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 19th 1947 19 ; at 6.15 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 13/ 1944 to Feb. 19 1947 and that I last saw him alive on Feb. 19 1947

Immediate cause of death: Pulmonary Tuberculosis — Duration 2 3/4 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Hunt M. D.
Address Baltimore City Hosp. Date signed 2-19-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18787

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93E

Registered No. G18787

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2717 Guilford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 - 3
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2717 Guilford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Nettie L. Shipley

3 (b) If veteran, name war W

3 (c) Social Security Account No. NONE

4. Sex Female

5. Color or race White

6 (a) ~~Single, married~~, widowed, or divorced. Widowed

6 (b) Name of husband Warren T. Shipley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 1st 1868

8. AGE: Years 78 | Months 3 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace New York, N.Y.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Rev John Langhan
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Elizabeth Andrews
15. Birthplace Balto. Md.

16 (a) Informant Mary E. Coale
(b) Address 2717 Guilford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) FEB 20 1947 (Date rec'd by registrar) (b) Interred for William Cook Inc. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18th 1947, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1, 1945, to 2/18 1947, and that I last saw ~~her~~ alive on 2/18 1947.

Immediate cause of death Chronic myocardial insufficiency — Duration 2 yrs.

Due to — Duration

Due to — Duration

Other Conditions Uterine cancer? Dry gangrene of rt. foot — Duration 2 mos.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place)
While at work?
(e) Means of injury

23. Signature J. Willis Compton M.D.
Address 3963 Government Ave Date signed 2/19/47

VS 150

G48788

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 63B

Registered No. G48788

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1116 E. 30th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-4
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 E. 30th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Jennie Neuhauser

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married, widowed, or~~ divorced: Divorced

6 (b) Name of husband ~~or wife~~: Frank

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Sept 26th 1892

8. AGE: Years 54 | Months 4 | Days 22 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business At Home

FATHER
12. Name Daniel Akers
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Fannie Browning
15. Birthplace Balto. Md.

16 (a) Informant Mrs Ella V. Wilson

(b) Address 3425 Dennison St.

(Burial, cremation, or removal) (b) Date thereof 2/21/47 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Cedar Hill

Location a. a. Co. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

19 Filed FEB 20 1947 (Date received by registrar) Huntington Williams M.D. (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18th 1947 at 5:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 9 1939 to Feb. 17 1947 and that I last saw h[illegible] alive on Feb. 17 1947

Immediate cause of death: Bronchitis

Due to (a) Bronchiectasis — Duration: 6.6 yrs.

Due to (b) Pharmic Goitre

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm P Johnson M.D.

Address 407 Medical Arts Date signed 2/19/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48789 BC# 970234

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

✓ G48789 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Division St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

4-2

3 (a) FULL NAME Baby J Jean Shorter (Robert Mitchell Shorter)
3 (b) If veteran, name war (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Negro | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 4, 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 2 | hr. min. |

9. Birthplace Balto., md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name James Shorter Jr.
13. Birthplace Philadelphia Pa.
MOTHER 14. Maiden Name Jean Jackson
15. Birthplace Gloucester, Va.

16 (a) Informant Jean Shorter
(b) Address 1514 Division St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) Date received by FEB 20 1947 (b) Registrar's signature Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 6, 1947, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 4, 1947, to Feb 6, 1947, and that I last saw him alive on Feb. 6, 1947.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Edema | |
| Due to Prematurity | |
| Due to 33 weeks | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Pulmonary edema

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred V Patterson M. D.
Address Provident Hospital

2/12/47

VS 150

Piskonowicz (or) Piszkowicz

# CERTIFICATE OF DEATH 58D

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. G48790

~~G18790~~

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3134 O'Donnell st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-1
(e) Length of stay in Baltimore (yrs., mos., or days) 34

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3134 O'Donnell st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paula or Paulina Piskonowicz or Piszkowicz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Alexander

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22" 1895

8. AGE: Years 51 | Months 8 | Days 28 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name Anthony Limanowicz

13. Birthplace Poland

MOTHER 14. Maiden Name Helen Bogdanowicz

15. Birthplace Poland

16 (a) Informant Mr. Alexander Piskonowicz

(b) Address 3134 O'Donnell st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 22/47 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus Kostka

Location

18 (a) Funeral Stephen J. Fialkowski INC

(b) Address 1000 S. Kenwood Ave

19 (a) FEB 20 1947 (Date rec'd by reg'istr.) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19" 1947, at 4 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1946, to Feb 19 1947, and that I last saw her alive on Feb 19 1947.

Immediate cause of death Chronic Pneumonitis

Myocardial Failure

| Duration |
|---|
| 1-15-46 |
| 2-1-47 |

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Eschenmeyer M. D.

Address 5424 Eastern Date signed 2-20-47

VS 190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48791

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G48791

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 311 Cathedral St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** James Leo Malone

3 (b) If veteran, name war: —
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | widower |

6 (b) Name of husband or wife Katharine Dempsey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 8 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 10 | 11 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business U.S. Custom House

FATHER
12. Name James Malone
13. Birthplace Ireland

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mrs Edward J Richardson Jr.
(b) Address 47 Whitfield Rd.

17 (a) Burial (b) Date thereof Feb 21
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bon Cathedral
Location Ogle. Md

18 (a) Funeral director Henry W. Jenkins & Son
(b) Address N Eutaw & Orchard Sts

19 FEB 20 1947 (Date rec'd by registrar) Lancaster Williams, M.D. Registrar

VS 181

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 1947, at 12 40 M

21. I certify that I took charge of the remains described above, held an Insp. & Inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mesesic, M.D.
Medical Examiner.
Date signed 2-19-47

G48792

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 163H

G48792 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3700 Nortonia Rd
(c) Hospital or institution: 15-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3700 Nortonia Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARY BROWNE INSKEEP

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: William C. Inskeep

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 14, 1918

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 29 | 1 | 4 | hr. min. |

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Carroll Browne
13. Birthplace: unknown

MOTHER
14. Maiden Name: unknown
15. Birthplace: unknown

16 (a) Informant: Mr. Wm. C. Inskeep
(b) Address: 3700 Nortonia Rd.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 2/21/47 (month) (day) (year)
(c) Cemetery or crematory: Greenmount Crematory
Location: Baltimore, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) FEB 20 1947 (Date rec'd by registrar) (b) Hunter Williams, M.D. Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/18 1947 at 8:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Asphyxiation due to illuminating gas

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2/18/47 at about 6:30 P.M.
(b) Where did injury occur? 3700 Nortonia Rd
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? no
(d) Means of injury Inhalation of gas from stove

23. Signature C. P. Sabinski M.D.
Medical Examiner.
Date signed 2/18/47

G18793

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

830

G18793 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address 18 W 25th St

(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-6

(e) Length of stay in Baltimore (yrs., mos., or days) all life

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md. (b) County Baltimore

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 18 W. 25th St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Alexander Armstrong Forman

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary Hesline Forman

6 (c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): July 28 1868

8. AGE: Years: 78 Months: 6 Days: 29 If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county and state)

10. Usual Occupation: Real Estate Dealer

11. Industry or business: Self

FATHER 12. Name: Alexander Darragh Forman

13. Birthplace: Delaware

MOTHER 14. Maiden Name: Elizabeth Armstrong

15. Birthplace: Baltimore

16 (a) Informant: Mrs Ada Forman

(b) Address: 18 W 25th

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/47 (month) (day) (year)

(c) Cemetery or crematory: Mt. Olivet Cem.

Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS

(b) Address: Balto., Md.

19 (a) FEB 20 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 19 1947 2.45 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Dec 1 1946 to Feb 19 1947 and that I last saw him alive on Feb 18 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 days

Due to: Arteriosclerosis — Duration: several yrs

Due to: aged — Duration:

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation:

of autopsy: —

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: H. L. Keffer M. D.

Address: Westminster Md Date signed: 2-19-47

VS 150

G48794

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 B

Registered No. G48794

1. PLACE OF DEATH:
(a) Baltimore City, Maryland (#18)
(b) Street address 33rd + Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore 29 (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 Lynchurst St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME RYDER, Miss Ethel Virginia

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 4, 1918
8. AGE: Years 28 Months 7 Days 14 If less than one day hr. 5 min.
9. Birthplace VIRGINIA (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Earl C. Ryder (L)
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Harrington
15. Birthplace Virginia

16 (a) Informant Hospital Records (UMH)
(b) Address 33rd + Calvert Sts. Balto 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 20 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1947, at 1:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2 1947 to Feb 19 1947 and that I last saw her alive on Feb 19 1947.

Immediate cause of death: CARCINOMA, METASTATIC, OF OVARY, BILATERAL — Duration

Due to secondary to carcinoma of stomach (Krukenberg tumor)

Other Conditions Colostomy (pt. was previously obstructed intestinal)

Date of operation 11-9-46 + 1-30-47 (Include pregnancy within 3 months of death)

Major findings of operation: First: Metastatic carcinoma; Second: Intestinal Obstruction, Sigmoid

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature A. V. Lucia, M.D.
Address UMH 33rd + Calvert Date signed 2-19-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G48795 BC# G55716

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 6

Registered No. G48795

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) ~~City~~ or town Randallstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Fowler, Richard (Richard N. Fowler) ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 13, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 5 6 | 6 | hr. min. |

9. Birthplace Baltimore Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Fowler, Edgar
13. Birthplace Sykesville, Maryland

MOTHER
14. Maiden Name Nelson, Hazel N.
15. Birthplace Beltsville, Maryland

16 (a) Informant Fowler, Edgar (father)
(b) Address Randallstown, Maryland

17 (a) Burial (b) Date thereof Feb. 20, 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Parran Cemetery
Location Harrisonville, Md.

18 (a) Funeral director Miles L. Amoreau
(b) Address 4510 Liberty Heights Ave.

19 FEB 20 1947 (b) Registrar by Mary Faughter Williams, M.D.
(Signature of Registrar)

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 1947, at 7 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 18 1947 to Feb. 19 1947 and that I last saw him alive on Feb. 19 1947

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | 20 hours |
| Due to Meningitis, Meningococcus | 2 days |
| Due to | |
| Other Conditions Pertussis | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert J. Sheldon M. D.
Address Sydenham Hospital Date signed 2/19/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48796

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 124a

Registered No. G48796

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 26-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4715 Eastern Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** CHARLES HODGES

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24-93.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | 6 7 | 26 | hr. min. |

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business ?

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs James Bates
(b) Address 1409 Eastern Ave Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem
Location Balto Co Md

18 (a) Funeral director James J Brizendine
(b) Address 1407 Eastern Ave Rd

19 (a) FEB 20 1947 (Date rec'd by registrar) Huntingtor Williamsville, Md.

VS 131

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 19, 1947 at 7.15 a M

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cirrhosis of Liver (alcoholic)
Ruptured esophageal varices with hemorrhage into stomach.
Ascites. Jaundice.
Myocardial degeneration
Edema of lungs
Edema of brain.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 2-19-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48797

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 195c

Registered No. G48797

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 122 N. Fremont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-1
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 122 N. Fremont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES SCOTT

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-03-6564

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1898

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 49 | 1 | 9 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name George Scott
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Richardson
15. Birthplace Md.

16 (a) Informant Mrs Florence Harman
(b) Address 505 N. Pine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cem.
Location A. A. Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 1572 W. Biddle St.

FEB 20 1947 (Date rec'd by registrar)

19 (a) (b) Huntington Williams M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 16 1947; at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/13/47 to 2/16/47 and that I last saw h[illegible] alive on 2/15/47

| Immediate cause of death | Duration |
|---|---|
| Uremia complicating Chronic Nephritis | 3 Hours |
| Due to Heart Work | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Lee Ellis M. D.
Address 944 Mosher St. Date signed 2/19/47

X

G48798

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G48798

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 937 N. Mount Street
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 937 N. Mount Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Hazelton

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Colored | Widowed |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1860

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 86 | 10 | | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace " "

MOTHER
14. Maiden Name Susie Tripp
15. Birthplace Md.

16 (a) Informant Mrs. Ethel Lewis
(b) Address 937 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 FEB 20 1947 (b) Thurlington Williams, M.D.
(Date received by registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 17 1947 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1947 to Feb 17 1947 and that I last saw him alive on Feb 17 1947

Immediate cause of death Cerebral Hemorrhage

| Duration |
|---|
| 1 Day |

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W H Davis M.D.
Address 515 Carlton Date signed 2-[illegible]-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G48799
TN.

BALTIMORE CITY HEALTH DEPARTMENT
108307 CERTIFICATE OF DEATH 13 B

Registered No. G48799

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 21-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 512 W. Cross St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Aldona Williams

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1st (1928) 1927

8. AGE: Years 19 (20) | Months 11 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Cleveland
13. Birthplace S.C

MOTHER
14. Maiden Name Mabel ~~Kuhn~~ Taylor
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 23-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director James Adams
(b) Address 142 Linden Ave

19 (a) FEB 20 1947 (Date filed by registrar) (b) Livingston Williams M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb. 19th 1947, at 8.15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10th 1947 to Feb. 19 1947, and that I last saw her alive on Feb. 19 1947.

Immediate cause of death Pulmonary Thrombosis — Duration 3 days

Due to — Duration 11 Months

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Hunt M. D.
Address Baltimore City Hospitals Date signed 2-19-47

X

G48800

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G48800

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 742 W. Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-2
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 742 W. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Earl Lee Ellis

3 (b) If veteran, name war —
(c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Nora C. Ellis
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) May 1, 1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 9 | 18 | hr. min. |

9. Birthplace Newark Md (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER — 12. Name John Ellis
13. Birthplace Md.

MOTHER — 14. Maiden Name Sallie Phillips
15. Birthplace Md.

16 (a) Informant Nora C. Ellis
(b) Address 742 W. Baltimore St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 21-1947 (month) (day) (year)
(c) Cemetery or crematory Pocomoke City
Location Worcester Co. Md.

18 (a) Funeral director Mrs. Mrs. John W. Teufel & Son
(b) Address 534 Edmondson Ave.

19 FEB 20 1947 (Date rec'd by registrar) Huntington Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1947, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/30 1946 to 2/19/1947 and that I last saw him alive on 2/17 1947

| Immediate cause of death | Duration |
|---|---|
| Cardiac thrombosis | 20 days |
| Due to Arterio Sclerosis | 6 mos |
| Due to | |
| Other Conditions Rectal stricture | 2 mos |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. F. Hawkins M. D.
Address Pocomoke Date signed

VS 150

Campbell

G48801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 21 B

G48801 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1022 Shields Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-2
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1022 Shields Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Anna Campbell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1877

8. AGE: Years 70 | Months 1 | Days 18 | If less than one day hr. min.

9. Birthplace Heathville Va (Town, county, and state)

10. Usual Occupation Domestic (cook)

11. Industry or business

MOTHER / FATHER

12. Name George Conley

13. Birthplace Heathville, Va

14. Maiden Name unknown

15. Birthplace Va

16 (a) Informant Joseph Campbell

(b) Address 1022 Shields Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem

Location E. L. County Md

18 (a) Funeral director William A Jackson

(b) Address 916 Pennsylvania Ave, Huntington West Virginia

19 (a) Date received by Local Registrar FEB 20 1947 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1947, at 6 55 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1946, to Feb 19 1947, and that I last saw h alive on Feb 17 1947.

Immediate cause of death: Tuberculosis of Orbit of left Eye — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Fisher M. D.

Address 1612 E Monument St Date signed 2/19/47

X

LASSNER

G48802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G48802

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. correct age is especially important. Physicians: please write t

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1413 Cold Spring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 Cold Spring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Johan Lassner

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | white | Single |

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 yrs | | | hr. min. |

9. Birthplace unknown
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Lassner
13. Birthplace Germany

MOTHER
14. Maiden Name Cora —
15. Birthplace Germany

16 (a) Informant Mrs Anna Vaughn
(b) Address 1413 Cold Spring ave

17 (a) Burial (b) Date thereof 2-21-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Balto.

18 (a) Funeral director Frank H Seitz
(b) Address 814 N 36 St

19 Date rec'd (Registrar) FEB 20 1947 Burlington for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 1947, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17 1947 to Feb 18 1947, and that I last saw h[im] alive on Feb 18 1947.

| Immediate cause of death | Duration |
|---|---|
| Arteriosclerosis | 2 |
| Myocardial disease | |
| Due to | |
| Due to Myocardial insufficiency | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard J. Mulkern, M.D.

Address 342 W Chestnut St Date signed 2/19/47

VS 150

G48803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73a

G48803
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1007 Vine St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
Street No. 1007 Vine St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Daniel Culver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Louise Culver

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1886

8. AGE: Years: 61 | Months: 8 | Days: 27 | If less than one day: hr. min.

9. Birthplace Prince Geo. Co. Md.
(town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Daniel Culver
13. Birthplace Prince Geo Co. Md.

MOTHER
14. Maiden Name Elizabeth Hicks
15. Birthplace West Indies Island

16 (a) Informant Ref Culver
(b) Address 1067 W. Lexington St.

17 (a) Burial (b) Date thereof Feb. 20 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory W. Calvary Cem.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

Feb 20 1947 (b) Contractor Williams M.D.
(Date) (Registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feby 16 1947 2 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/20/47 1947 to 2/16/47 1947 and that I last saw h alive on 1/20/47 1947.

Immediate cause of death Duration

Pernicious Anemia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. A. Bowles M.D.

Address 600 N. Carrollton Date signed 2/25/47

G48804

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1131a

Registered No. G48804

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 163 Colvin St
(c) Hospital or institution: 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yr.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 163 Colvin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Albert Archer

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Col | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 47 | 0 | 28 | hr. min. |

9. Birthplace Washington D.C. (Town, county and state)
10. Usual Occupation Handy man
11. Industry or business

FATHER
12. Name Albert Archer
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Elizabeth Craig
15. Birthplace Washington, D.C.

16 (a) Informant Beatrice Maynard
(b) Address 1352 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof FEB 21 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1516 Orleans St

19 (a) FEB 20 1947 (Date received) Huntington Williams, M.D. Registrar

2/18/47

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 2/18 1947 at 10:45 M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2/14 1947 to 2/18 1947, and that I last saw h[illegible]ive on 2/17 1947

| Immediate cause of death | Duration |
|---|---|
| Cardio-Vascular Renal disease - | |
| Arteriosclerosis. | 14 yr. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23.** Signature [signature] M.D.
Address 1200 Darlington Ave Date signed 2/18/47

X

VS 150

G48805

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G48805

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 105 S. Caroline St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 -
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 105 S. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Virginia B. Wilkes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-17-1919

8. AGE: Years 27 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Greenville N.C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name William Wilkes

13. Birthplace N. C.

MOTHER 14. Maiden Name Mordecie Payton

15. Birthplace N.C.

16 (a) Informant Dessie Wilkes

(b) Address 105 S. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 20, 1947 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson

(b) Address 1510 Orleans St

19 (a) FEB 20 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16 1947, at 2 P.M. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-10- 1947 to 2-16- 1947, and that I last saw h[illegible] alive on 2-16-47 19

Immediate cause of death: Coronary Thrombosis — Duration: 1 week

Due to ?

Due to ?

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis E. Warren M. D.

Address 2340 Madeira Date signed 2-16-47

VS 150

G48806

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

G48806 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2928 Southland ave.
(c) Hospital or institution: Home 25-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2928 Southland Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William Harry Graham

3 (b) If veteran, name war

3 (c) Social Security Account No. 185-05-3002

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Negro | Married |

6 (b) Name of husband or wife Alice Hammond Graham
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) June 2, 1892

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 yrs. | 8 | 16 | hr. min. |

9. Birthplace (State or Foreign Country) Hillsboro, N.C. (Town, county, and state)
10. Usual Occupation Door Keeper (movie theatre)
11. Industry or business

FATHER
12. Name Augustus Graham
13. Birthplace Charlotte, NC.

MOTHER
14. Maiden Name Harriet Works
15. Birthplace Charlotte, NC.

16 (a) Informant Mrs. Alice Hammonds Graham
(b) Address 2928 Southland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 20, 1947 (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Mt. High Baptist, N.C.

18 (a) Funeral director Chas. H. Stallings
(b) Address 1601 Druid Hill Ave.

FEB 20 1947 (Date received) Huntington Williams (Registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-18 1947, at 10:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-16 1947, to 10:05 P.M. 2-18 1947, and that I last saw h[illegible] alive on 2-18 1947.

Immediate cause of death: Cerebral Hemmorhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerry M. Francis M. D.
Address 393 Bridgeview Date signed 2/19/47

X

The G18807

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G18807

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2709 Overland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2709 Overland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Francis Czarnowsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Margaret Irene
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25, 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 7 | 25 24 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Pres-Type Founding
11. Industry or business

FATHER
12. Name Ferdinand Czarnowsky
13. Birthplace Md.

MOTHER
14. Maiden Name Helena Marks
15. Birthplace Md.

16 (a) Informant Mrs. Margaret Czarnowsky
(b) Address 2709 Overland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (Date received by registrar) FEB 20 1947 Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19, 1947, at 3 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 26 1946, to Feb 19 1947, and that I last saw him alive on Feb 18 1947.

Immediate cause of death: Carcinoma Left Lung — Duration 1 Year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations: —

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide none
(b) Date of occurrence at M
(c) Where did injury occur? none (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury none

23. Signature L. L. Gordy M.D.
Address 5106 Harford Rd Date signed 2-18-47

X

Birth Certificate

G-7470

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

161c

Registered No. G48808

G48808

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 21 hrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 23 B Oak Grove drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Muhly

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | S |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | 21 hr. min. |

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Stu

11. Industry or business

FATHER
12. Name John Henry Muhly Jr.
13. Birthplace Balto.

MOTHER
14. Maiden Name Mary Doris Via
15. Birthplace Baltimore

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) FEB 20 1947 (Date received by Registrar) (b) Huntingdon Williamsport

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19, 1947, at 8 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-18 1947 to 2-19 1947 and that I last saw h~~im~~ alive on 2-19 1947

Immediate cause of death: respiratory failure — Duration: 21 hrs.

Due to: erythroblastosis fetalis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 2-18-47

Major findings of operations: exchange transfusion

of autopsy: jaundice, hepatomegaly

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James J. Gulack M. D.

Address Mercy Hosp. Date signed 2-19-47

X

The G18809

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G18809

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Linden and Madison Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Va (b) County
(c) City or town Remo
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Bernice Lee Headley

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | M |

6 (b) Name of husband or wife IONE HEADLEY
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) MAY 6, 1901

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 45 | 9 | 14 | hr. min. |

9. Birthplace REMO, VIRGINIA NORTHUMBERLAND
(Town, county, and state)
10. Usual Occupation MECHANIC
11. Industry or business SELF

FATHER
12. Name CHARLES H HEADLEY SR.
13. Birthplace VIRGINIA.

MOTHER
14. Maiden Name JOSEPHINE LAWSON
15. Birthplace VIRGINIA.

16 (a) Informant MRS. HIRAM H THRIFT.
(b) Address WICOMICO CHURCH VA.

17 (a) Removal (b) Date thereof 2/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Wicomico Baptist Cem.
Location Remo Virginia

18 (a) Funeral director. Wm Cook Inc
(b) Address 1217 St Paul St

FEB 20 1947 (b) Huntington Williams, M.D.
(Date received by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 20th 1947; at 11A 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/14/1947 to 2/20/1947 and that I last saw h 12s alive on 2/20/1947.

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure | |
| Due to Intracranial cerebral hemorrhage | 6 days |
| Due to H.C.V. Disease | |
| Other Conditions Rt hemiplegia | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Gonzalez M.D.
Address Maryland Eastern Shore. Date signed 2/20/47

VS 150

X

G48810

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G48810

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 51st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 87 days
(e) Length of stay in Baltimore (yrs., mos., or days) 87 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Va. (b) County
(c) City or town Norfolk (If outside city or town limits, write RURAL and give town)
(d) Street No. 918 Bermuda St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Myers, Norman Chester

3 (b) If veteran, name war

3 (c) Social Security Account No. 159-18-2482

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | col | Married |

6 (b) Name of husband or wife Lethia Davis
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) July 4, 1904

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 42 | 7 | 12 | hr. min. |

9. Birthplace Norfolk, Va. (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Seafarer

FATHER
12. Name George Myers
13. Birthplace NC

MOTHER
14. Maiden Name Annie Thomas
15. Birthplace NC

16 (a) Informant Records
(b) Address Us Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 20 47 (month, day, year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Norfolk Va
18 (a) Funeral director Odell Funeral Home
(b) Address 403 E. 25th St.
19 (a) FEB 20 1947 (Date rec'd by registrar) Huntington Williams M.D. (Signature of registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 16 19 47, at 8:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21 19 46, to Feb. 16 19 47 and that I last saw him alive on Feb. 16 19 47

Immediate cause of death Carcinoma left breast with diffuse metastasis to the pleura bilaterally — Duration 2 yrs.

Due to

Due to

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 2/19/47

G48811

AB-107605

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 125a

Registered No. G48811

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo, 5days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 Harford Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph McCubbin (Joseph S.Mc.Cubbin)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 213-05-6346

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Rose M.Kelly
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) March 3- 1874

8. AGE: Years 72 | Months 11 | Days 16 | If less than one day ____hr. ____min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Brass Moulder

FATHER 12. Name Joseph McCubbin

13. Birthplace Maryland

MOTHER 14. Maiden Name Agnes E.Wagner

15. Birthplace Baltimore, Md.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue Balto:Md.

18 (a) Funeral director George J.Ruth, Inc.
(b) Address 1735 Harford Avenue

FEB 20 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

**MEDICAL CERTIFICATION** AM

20. DATE OF DEATH Feb. 19- 1947, at 5.23 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-14 1947 to 2-19 1947 and that I last saw him alive on 2-19- 1947.

| | Duration |
|---|---|
| Immediate cause of death: Acute yellow atrophy | 6 weeks |
| Due to: Leukemia Simplex | 3 yrs. |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. R. Hufferman M. D.
Address Baltimore City Hosp. Date signed 2/24/47

VS 150

X

G48812

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 187c

G48812 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1413 E. Lafayette Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9 None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 E Lafayette Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** George Peter Schreiber

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Christina A. Wilhelm
6 (c) If alive, give age: 81 years

7. Birth date of deceased (mo., day, yr.): July 5, 1866

8. AGE: Years: 80 | Months: 7 | Days: 13 | If less than one day: ######## min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business: Bricklayer

FATHER
12. Name: Philip Schreiber
13. Birthplace: Germany

MOTHER
14. Maiden Name: Catherine Buettner
15. Birthplace: Germany

16 (a) Informant: Mrs. Christina A. Schreiber
(b) Address: 1413 E. Lafayette Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd. Balto: Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 FEB 20 1947 Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION** 12.15

20. DATE OF DEATH Feb. 18 1947, at 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 16 1947 to Feb. 18 1947, and that I last saw him alive on Feb. 17 1947.

| Immediate cause of death | Duration |
|---|---|
| Terminal Pneumonia | 3 days |
| Due to Arterio Sclerosis | 10 yrs |
| Parkinson Syndrome | 10 " |
| Due to advanced age | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles T. Bryant M. D.
Address 3812 Greenmount Ave Date signed 2/18/47

VS 150

G48813

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G48813

1314a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1714 Montpelier
(c) Hospital or institution: 9-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 Montpelier Street
(If rural, give location) No
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Christopher

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Larken Christopher
6 (c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.) June 25, 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 7 | 24 | ##### hr. ____ min. |

9. Birthplace Germany (town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Franz Bachman
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Anna Bohnet
(b) Address 1714 Montpelier Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) FEB 20 1947 Huntington Williams, M.D. Registrar

V S 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 19 1947, at 1 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1947 to Feb 19 1947, and that I last saw h[illegible] alive on Feb 18 1947.

| Immediate cause of death | Duration |
|---|---|
| Decompensated Mitral Regurgitation | 10d. |
| Due to Arterio Sclerosis + Hypertension | 10d. |
| Due to Chr. Interstitial Nephritis | 10d. |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. F. A Strong M. D.
Address 2878 Harford Rd Date signed 2-19-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48814

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 92B

G48814 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County A. A. County
(c) City or town Royal Beach
(If outside city or town limits, write RURAL and give town)
(d) Street No. Pasadena
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARLETT Harry [illegible] Maraton

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-10-1892

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 | 5 | 8 | hr. min. |

9. Birthplace BALTO - Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name CHAS Kraft

13. Birthplace Md.

MOTHER 14. Maiden Name Sarah Monroe

15. Birthplace Md.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/21/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md

18 (a) Funeral director L. A. Kilpatrick Son

(b) Address Eastern Ave - Lauraville

19 (a) FEB 20 1947 (Registrar) (b) Huntington Williams M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 18 1947, at 2.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 18 1947 to Feb. 18 1947, and that I last saw h. m. alive on Feb 18 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral embolus with right hemiplegia | 8 hrs |
| Due to Rheumatic heart disease with mitral stenosis | ? |
| Due to and auricular fibrillation | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert C. Austen

Address Johns Hopkins Hosp. Date signed 2-20-47

X

C48815 DC# 63718

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 160a

Registered No. C48815

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1020 E. Hoffman St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No 1020 E. Hoffman St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn M. Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 4th 1946

8. AGE: Years | Months: 2 | Days: 25 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER — 12. Name George L. Smith
13. Birthplace Md

MOTHER — 14. Maiden Name Helen L. Johnson
15. Birthplace Md

16 (a) Informant George L. Smith
(b) Address 1020 E. Hoffman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 21st 1947 (month) (day) (year)
(c) Cemetery or crematory New Leatherdale
Location Edmondson Ave

18 (a) Funeral director Leo G. Leo
(b) Address 1701-03 N. Patterson Park Ave

19 (a) FEB 20 1947 (Date rec'd by registrar) Thurlington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19th 1947, at 10:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1947, to Feb 19 1947, and that I last saw her alive on 19

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | |
| Due to Probably due to | |
| Due to Injuries of brain & skull | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jos L. Valentine M. D.
Address 132 N. Broadway Date signed Feb 20 47

VS 150

Sudie

50899 G48816

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

46E

R. G48816

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Dorchester
(c) City or town Cambridge (If outside city or town limits, write RURAL and give town)
(d) Street No. 105 Washington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Sudie Rawley.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-27-75

8. AGE: Years 71 | Months 8 | Days 24 | If less than one day hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Simm Harris

13. Birthplace N.C.

MOTHER 14. Maiden Name Frances Walston

15. Birthplace N.C.

16 (a) Informant Branch.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 23/47 (month) (day) (year)

(c) Cemetery or crematory Cemetery

Location Cambridge Md

18 (a) Funeral director Lewis (-) Blackmon

(b) Address Cambridge Md

19 (a) Date received by local registrar Feb 20 1947 (b) Registrar for Williams Hill

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 20 1947, at 3.13 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 29 1947, to Feb. 20 1947, and that I last saw h. alive on Feb. 20 1947.

| | Duration |
|---|---|
| Immediate cause of death: Cerebral thrombosis | |
| Due to: Surgical operation for Carcinoma of sigmoid | |
| Due to: | |
| Other Conditions: Carcinoma of sigmoid | |

(Include pregnancy within 3 months of death)

Date of operation Feb 7, 1947

Major findings of operation: Carcinoma of sigmoid

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature K. J. Tanner Jr.

Address Johns Hopkins Hospital Date signed 20 Feb 47

G48817

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 194a

G48817 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2456 Callow Ave
(c) Hospital or institution: 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2456 Callow Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** JOSEPH LEVY

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: ROSY
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1871
8. AGE: Years 76 | Months | Days | If less than one day hr. min.
9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name LAIB
13. Birthplace RUSSIA

MOTHER
14. Maiden Name HANNAH
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-21-47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto & Coggeshall Sts

18 (a) Funeral director Jack Lewis Inc.
(b) Address 1439 E. Balto St.

FEB 21 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/20/47 19..., at 8:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1937 to 2/20 1947. and that I last saw him alive on Feb 20 1947.

| Immediate cause of death | Duration |
|---|---|
| (a) Coronary occlusion | Sudden |
| Due to (b) coronary occlusion | 1937 |
| Due to (c) arterio-sclerosis | 10 yrs |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [signature] M. D.
Address 1722 Eutaw Pl Date signed 2/20/47

G48818

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48818 Registered No.

1137a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write up the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution:
Sinai Hosp Balt Md
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3717 Spaulding Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Isaac Stein

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business

FATHER
12. Name Aaron
13. Birthplace Russia

MOTHER
14. Maiden Name Ida
15. Birthplace Russia

16 (a) Informant Dr Milton R Stein
(b) Address Alexander Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Hamilton Ave & Pulaski Rd

18 (a) Funeral director Jack Levin Inc
(b) Address 1429 E Balto St

19 (a) 2-21-1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 20 Feb 1947, at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8 Feb 1947 to 20 Feb 1947 and that I last saw h[illegible] alive on 20 Feb 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure | |
| Due to acute coronary occlusion | |
| Due to Coronary atherosclerosis | |
| Other Conditions Benign Prostatic Hypertrophy - Transurethral Resection | |

(Include pregnancy within 3 months of death)
Date of operation 18 Feb 47
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hurwitz Gordon M.D.
Address Sinai Hosp Date signed 20 Feb 47

VS 150

G18819

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G18819
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1443 Patapsco St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 7 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 5 7 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1443 Patapsco St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Rose Genevieve Reeder.

3 (b) If veteran, name war None | 3 (c) Social Security Account No. 216-10-8077

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1897

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 11 | 12 | hr. min. |

9. Birthplace Water Survey Anne Arundel Co. (Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business Rosen Room Co

| | |
|---|---|
| FATHER | 12. Name Samuel J. Reeder |
| | 13. Birthplace Md |
| MOTHER | 14. Maiden Name Alice M. Wilson |
| | 15. Birthplace Md |

16 (a) Informant Edna E. Reeder, sister
(b) Address 1443 Patapsco St Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 22, 1947 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Anne Arundel Co

18 (a) Funeral director C. Hoffman Eaton
(b) Address 1440 S. Charles St

Registered by Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 19 1947, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1946 to Feb. 19 1947 and that I last saw h[illegible] alive on Nov Feb 19 1947

| Immediate cause of death | Duration |
|---|---|
| Aortic Dilatation & Insufficiency | 15 min. |
| Due to Myocarditis | 3 y |
| Due to Arteriosclerosis | 8 y |
| Other Conditions Bronchial Asthma | 7 y |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter Kohn
Address 826 Fort Ave Date signed 2/20/47 M. D.

VS 190

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C 18820

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1706

Registered No. C 18820

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 2447 Fair Way (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Anthony De Luca

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-16-0564

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Julia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21 1899

8. AGE: Years 47 | Months 6 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace: Cosenza Italy (Town, county, and state)

10. Usual Occupation: Restaurant Manager

11. Industry or business: Restaurant

FATHER
12. Name: George De Luca
13. Birthplace: Italy

MOTHER
14. Maiden Name: Rosina Borelli
15. Birthplace: Italy

16 (a) Informant: Julia De Luca (Wife)
(b) Address: 2447 Fairway Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 22 1947 (month) (day) (year)
(c) Cemetery or crematory: Sacred Heart
Location: Germanhill Rd.

18 (a) Funeral director: Frank Della Rocca
(b) Address: 52 N. Mcrley St.

19 (a) FEB 21 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: February 19 1947, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fractured 2nd and 3rd cervical vertebrae (broken neck)
Intrathoracic hemorrhage,
Subarachnoid hemorrhage,

Other Conditions: Fractured ribs, fractured pelvis, laceration, bruises and brush burns
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: Code No. 24
(a) Date of injury 2/18/47 12 A.M.
(b) Where did injury occur? St. Helena Ave. and Dundalk Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Crushed between streetcar and [illegible]

23. Signature: Howard J. Mullins M.D. Medical Examiner.
Date signed 2-19-47

VS 151

G18821 BG# G 65767 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 157E Registered No. G18821

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL 94
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County.....
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 717 E. 41st (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME RICHARD LAWRENCE JONES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: White

5. Color or race: Male

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 23rd 1946

8. AGE: Years | Months: 1 | Days: 26 27 | If less than one day: 1 hr. ..... min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER 12. Name Raymond L. Jones
13. Birthplace Dublin, Harford Co. Md.

MOTHER 14. Maiden Name Dorothy Harrison
15. Birthplace Balto. Md.

16 (a) Informant Raymond L. Jones
(b) Address 717 E. 41st St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 2/21/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

(c) FEB 21 1947 (Date rec'd by registrar) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/19 1947, at 5 50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/19 1947, to 2/19 1947, and that I last saw him alive on 2/19 1947

Immediate cause of death CARDIAC AND RESPIRATORY FAILURE — Duration 15 MIN.

Due to CONGENITAL HEART DISEASE

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy: CONGENITAL HEART DISEASE

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Charles W. Stewart Jr. M. D.
Address Md. Gen. Hosp. Date signed 2/19/47
for Dr. J.B. Davis, by Howard J. Lineaweaver, M.D.

VS 150

G18822 Sawyer

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G18822 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 6028 Old Harford Road
(c) Hospital or institution:
Beach Hill Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3111 Reucksert Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Catherine Laur

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 1, 1863

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 11 10 | 19 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name George Laur
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Auer
15. Birthplace Md.

16 (a) Informant Mrs. Joseph Grenninger
(b) Address 3111 Reuckert Avenue

17 (a) Burial (b) Date thereof 2/ /47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road -14-

FEB 21 1947 (a) (b) Huntington Williams M.D.
(Date received) (Registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 20, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 14 1942 to Feb 20 1947, and that I last saw her alive on Feb. 19 1947.

| Immediate cause of death | Duration |
|---|---|
| Arteriosclerotic Heart Disease | 5 yrs. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Dawson M.D.
Address 4808 Harford Rd. Date signed 2/20/47 M. D.

X

G48823

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 107

G48823 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 109 W. York
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30

**2. USUAL RESIDENCE OF DECEASED:**
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 109 W. York (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Henry H. Dailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Colored | Married |

6 (b) Name of husband or wife Edith Dailey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 55 | | | hr. min. |

9. Birthplace md (Town, county, and state)
10. Usual Occupation Day Laborer
11. Industry or business

FATHER
12. Name John Dailey
13. Birthplace md

MOTHER
14. Maiden Name Emily Dailey
15. Birthplace md

16 (a) Informant Edith Dailey
(b) Address 420 S. Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director James A. Hayes
(b) Address 142 W. Lee St

FEB 21 1947 (b) Huntington Williams, M.D. Registrar
(a) Date rec'd by registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-20 1947, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 14 1947, to Feb. 20 1947, and that I last saw him alive on Feb. 20 1947.

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia (cause unknown) | 6 days |
| Due to | |
| Due to | |
| Other Conditions Malnutrition | unknown |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John W. Gaines, M. D.
Address 567 W. Hamburg St Date signed 2/24/47

G48824

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 83a

G48824
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4105 Hague ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 ✓
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4105 Hague ave
(If rural give location)
(e) Citizen of foreign country? non (Yes or No)
If yes, name country —

3 (a) FULL NAME Dora Della Leonard

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex fem | 5. Color or race white | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife John Leonard

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 26 1860

8. AGE: Years 86 | Months 32 | Days 6 24 | If less than one day — hr. — min.

9. Birthplace Garrison N. Y.
(Town, county, and state)

10. Usual Occupation house work

11. Industry or business

FATHER
12. Name Abram Ryan
13. Birthplace Peekskill N. Y.

MOTHER
14. Maiden Name Anna Foley
15. Birthplace Albany N. Y.

16 (a) Informant Mrs Deborah A Daughtry
(b) Address 4105 Hague Ave

17 (a) Burial (b) Date thereof 2/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Locust Point Cem
Location Hennans Hill Road

18 (a) Funeral director Lilly & Zeiler Inc
(b) Address 402 N Eutaw St

19 (a) FEB 21 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

VS 2

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20th 1947, at 3 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1946 to Feb 19 1947.
and that I last saw h[illegible] alive on Feb 19 1947.

Immediate cause of death Cerebral hemorrhage — Duration 16 days
Due to Arteriosclerosis — months
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature H Z Summers M. D.
Address 1175 Parkman Date signed 2-20-47

One X

G48825

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 137a

G48825 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Union ~~Hospital~~ 3500 W. Baltimore
(c) Hospital or institution: Union Memorial Hosp. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Months 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 67 years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Bolton St.
(If rural give location)
Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. O'Donovan

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | S. |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 31 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 8 | 19 20 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John O'Donovan
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret O'Brien
15. Birthplace Maryland

16 (a) Informant Bonita Jerry O'Donovan
(b) Address 1615 Bolton St Balt.

17 (a) Burial (b) Date thereof Feb 24 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Govts. Md

18 (a) Funeral director Henry M. Jenkins Sons
(b) Address McCulloh & Eutaw Sts

FEB 21 1947
(Date rec'd by Registrar) (By) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1947, at 9:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1946 to Feb 19 1947 and that I last saw him alive on Feb 1947.

Immediate cause of death: Cardiac decompensation — Duration: 2 days

Due to: Sepsis

Due to: Transurethral resection for Benign prostatic hypertrophy

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation February 18, 1947
Major findings of operation: Benign prostatic hypertrophy
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

23. Signature Joseph C. Preston M. D.
Address Union Memorial Hosp. Date signed Feb 19 1947

VS 150

G18826

BCH G42277

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

108

Registered No. G18826

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 7 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 653 W. Barre St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES MOORE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 18, 1946

8. AGE: Years 1 | Months - | Days 1 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation -

11. Industry or business

FATHER
12. Name Louis Johnson
13. Birthplace Md

MOTHER
14. Maiden Name Maria Moore
15. Birthplace Md

16 (a) Informant Mary Harvey
(b) Address 653 W Barre St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County

18 (a) Funeral director Mr. Robert J. Eldridge
(b) Address 1139 N. Carlton St.

FEB 21 1947 (Date rec'd by Reg.) Wm. Williams, M.D. Registrar

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 19, 1947, at 6.25 a M

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 2-19-47

X

G48827

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G48827

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:** D.O.H.
(a) Baltimore City, Maryland
(b) Street address 1710 N. Fulton Ave
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Jane [redacted] Gibson

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | Widow |

6 (b) Name of husband or wife Daniel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | | | hr. min. |

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Henry Bevans
13. Birthplace Va.

MOTHER
14. Maiden Name Louisa Roselle
15. Birthplace Va.

16 (a) Informant James Bevans
(b) Address 2433 Francis St

17 (a) Burial (b) Date thereof Feb 21 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Lebanon Cem
Location

18 (a) Funeral director Mrs Peters & Elbert Dyf
(b) Address 1129 N. Caroline St

19 (a) 2-21-1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/18 1947, at 3:00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to h[illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C.V disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C.P. Sabuda M.D.
Medical Examiner.
Date signed 7/10/47

VS 191

G48828

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

Registered No. G48828

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Oliver & Carolina
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 113 E Cross street
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

**3 (a) FULL NAME** Antonio Di Girolamo

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-12-2024

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Marian Di Girolamo 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 4, 1863

8. AGE: Years 83 84 | Months 6 | Days 15 | Less than one day ____ hr. ____ min.

9. Birthplace Italy (Town, county and state)

10. Usual Occupation Retired Construction

11. Industry or business

FATHER
12. Name Theodore Di Girolamo
13. Birthplace Italy

MOTHER
14. Maiden Name not known
15. Birthplace Italy

16 (a) Informant Vincent John Di Girolamo
(b) Address 112 E. Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 22/47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cemetery
Location 4430 Belair Rd.

18 (a) Funeral director Calvin Smith Earle Inc
(b) Address 115 E West St.

FEB 21 1947 (Date received by local reg.) (b) [illegible] for Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/19 1947, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/16/ 1947 to 2/19/1947, and that I last saw h.r alive on 2/19 1947

| Immediate cause of death | Duration |
|---|---|
| Coma | |
| Due to Cerebral Hemorrhage | |
| Uremic Poisoning | |
| Due to | |
| Other Conditions Diabetes Mellitus | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Cerebral Hem.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard A. Yanni M. D.
Address St. Josephs Hosp. Date signed 2/19/47

VS 150

83a

G48829

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48829 Registered No. 1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 417 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** FRANK O. HERBST

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 215-05-1473

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bessie N. Codle Herbst

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 1 | 26 | 23 hr. min. |

9. Birthplace: Glen Rock, Penna. (Town, county, and state)

10. Usual Occupation: Engraver

11. Industry or business: Z. F. W. Donahan

FATHER
12. Name: William H. Herbst
13. Birthplace: Glen Rock, Penna.

MOTHER
14. Maiden Name: Not known
15. Birthplace: Penna.

16 (a) Informant: Mrs. Bessie N. Herbst
(b) Address: 417 E. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-47 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: East End of North Ave.

18 (a) Funeral director: Chas. H. Corkran & Son
(b) Address: 924 E. Eager St.

19 (a) FEB 21 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 20, 1947, at 8 a. M

21. I certify that I took charge of the remains described above, held an autopsy, & saw thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Cardio vascular renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wallace M.D. Medical Examiner.
Date signed 2-20-47

G48830

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 127a

G48830 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secour Hosp. 6-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 159 N Gilmor St (Rural: give location)
(e) Citizen of foreign country? Country (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lena Wolf
3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex F. 5. Color or race W. 6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife Abe Wolf
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 29 1869
8. AGE: Years 55 Months 2 Days 20 If less than one day hr. min.
9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Stockman
13. Birthplace Balto

MOTHER
14. Maiden Name Susanna Thoon
15. Birthplace Balto

16 (a) Informant Mrs Rose Rainford
(b) Address 3936 Lawndale Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 17 47 (month) (day) (year)
(c) Cemetery or crematory Bells Lane
Location North Ave
18 (a) Funeral director L. Hermann & Son
(b) Address 6067 Harford Rd.
FEB 21 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb 16 1947, at 5-30 PM

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2/14 1947 to Feb 16 1947 and that I last saw h.. alive on Feb 16 1947.

| | Duration |
|---|---|
| Immediate cause of death: Cerebral Hemorrhage a embolism | |
| Due to: Hypertension or post operative | |
| Due to: | |
| Other Conditions: Pt. had Cholecystectomy Feb. 15, 1947 (Include pregnancy within 3 months of death) | |
| Date of operation: Feb. 15, 1947 | |
| Major findings of operation: Chr. Cholecystitis | |
| of autopsy: | |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature J R Liberto M. D.
Address Bon Secour Hosp Date signed 2/19/47

VS 180

G48831

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 92 B

G48831 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 6003 Edna Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) —

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 6003 Edna Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Alberta Kusch Kirsch

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F. | W. | Married |

6 (b) Name of husband or wife Wm. F.
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Aug 17. 1888

| 8. AGE: Years | Months | Days | If less than one day: hr. | min. |
|---|---|---|---|---|
| 58 | 6 | | | |

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

| | |
|---|---|
| FATHER 12. Name | Howard Cunningham |
| 13. Birthplace | Balto |
| MOTHER 14. Maiden Name | Mary Murphy |
| 15. Birthplace | Frederick Co Md |

16 (a) Informant Mr. Wm. F. Kirsch
(b) Address 6003 Edna Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 21. 47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location North Ave

18 (a) Funeral director L. Hegyi and Son
(b) Address 2 to 6067 Harford Rd

19 (a) 2-21-1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 18, 1947, 1947, at 11:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2, 1947, to Feb. 18, 1947. and that I last saw her alive on Feb. 18 1947.

| Immediate cause of death | Duration |
|---|---|
| Acute dilatation of Heart | 5hrs. |
| Due to Mitral stenosis & Aortic regurgitation. | 2 yrs. |
| Due to | |
| Other Conditions Osteitis Deformans (Include pregnancy within 3 months of death) | 55 yrs. |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elmer F. Engwald M.D.
Address 1613 E. North Ave Date signed 2-M.D.-1947

VS 180

G48832

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 186a

Registered No. G48832

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Madison at Linden
(c) Hospital or institution Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3100 Montebello Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Margaret B. Fischer

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | Wh | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 24 Sept. 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 4 | 26 | hr. min. |

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired Store Keeper
11. Industry or business

FATHER
12. Name Gottlieb H. Fischer
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Heil
15. Birthplace Germany

16 (a) Informant Mrs H Schmidt
(b) Address 3202 Gittings Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location E North Ave

18 (a) Funeral director Milton Schilling
(b) Address 3414 Hanover St

19 FEB 21 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 20 Feb. 1947, at 11:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 16 Nov. 1946, to 20 Feb. 1947, and that I last saw h.C.R alive on 20 Feb. 1947.

Immediate cause of death Cardiac decompensation — Duration

Due to

Due to

Other Conditions Pulmonary embolism, fracture of femur
(Include pregnancy within 3 months of death)

Date of operation 16 Nov. 1946

Major findings of operation: Gangrene and leg splint

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27/2

(a) Accident, ~~suicide or~~ homicide
(b) Date of occurrence 14 Nov. 1946 at 2 P.M.
(c) Where did injury occur? Baltimore Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Fell in her attic

23. Signature M.F. Mc Morgan M. D.
Address Md. Gen. Hosp. Date signed 20 Feb. 1947

Howard J. Mercer, M.D. X

G48833 BCH G71000

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 157E

Registered No. G48833

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Halethorpe
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3816 Benson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Purkey
3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/17/47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 36 hr. 2 day | - | 2 | hr. min. |

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name John Purkey
13. Birthplace Baltimore

MOTHER 14. Maiden Name Rose
15. Birthplace Baltimore

16 (a) Informant Rose Purkey
(b) Address 3816 Benson Ave
17 (a) Burial (b) Date thereof 21 Feb 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Pauls
Location Violetville Road
18 (a) Funeral director L. B. Weyforth & Son
(b) Address 1200 Eastern Ave

FEB 21 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feby 19 1947, at 10 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from Febr. 17 1947 to Feby 19 1947, and that I last saw him alive on Feby 19 1947.

| Immediate cause of death | Duration |
|---|---|
| (a) Absent Interventricular Septum | 1 hr. |
| Due to (b) congenital heart disease | 36 hrs. |
| Due to (c) | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: absent Interventricular septum found at autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23. Signature** Pearl Pass, M.D.
Address 4001 W. Lehens Ave Date signed 2-20-47

VS 150

G48834

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. G48834

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3831 Yolando Road.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3831 Yolando Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** E. CHARLOTTE - MANLY.

3 (b) If veteran, name war: None.

3 (c) Social Security Account No. 212-05-1933

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Arthur H. Manly.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20-1905

8. AGE: Years 41 | Months 9 | Days 30 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Clerk -

11. Industry or business C. & P. Telephone Co.

FATHER
12. Name John A. Werner.
13. Birthplace Baltimore - Md.

MOTHER
14. Maiden Name Emma Londenslager
15. Birthplace Baltimore - Md.

16 (a) Informant Mrs. Arthur H. Manly.
(b) Address 3831 Yolando Road.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Feb. 22-47. (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cemetery,
Location

18 (a) Funeral director Charles J. Schwab.
(b) Address 3612 Frederick Ave.

FEB 21 1947 (Date rec'd by registrar)

(Huntington-Williams Memorial)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 19- 1947, at 1.30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1947 to Feb 19 1947 and that I last saw her alive on 2/19 1947

Immediate cause of death: Cerebral Hemorrhage. — Duration: Sudden

Due to: Respiratory Paralysis — 24 hrs.

Due to: Bronchial Asthma. — 7 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence, at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph D. Bloom M. D.

Address 120 E. Preston St. Date signed 2/20/47.

G48835

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93E

Registered No. G48835

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Union Hospital
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balt.
(c) City or town Owings Mill (If outside city or town limits, write RURAL and give town)
(d) Street No. Kingsley Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lola E Miles

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife Nelson R. Miles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 21 1897

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 5-7 | | 19 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edward Wrights
13. Birthplace Md.

MOTHER
14. Maiden Name Della Snapp
15. Birthplace Md.

16 (a) Informant Nelson C Miles
(b) Address Owings Mills

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 24-47 (month) (day) (year)
(c) Cemetery or crematory Church of God.
Location Bethel Carroll Co.

18 (a) Funeral director J. F. Rose Sons
(b) Address Westminster

19 FEB 21 1947 (Registered by registrar) Huntington W. Blakistar, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21, 1947, at 7:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 8, 1947 to Feb 21 1947 and that I last saw h alive on Feb. 21 1947.

Immediate cause of death Cardio-Resp. failure

| Duration |
|---|
| |
| |
| |
| |
| |

Due to Pulmonary edema

Due to Coronary thrombosis

Other Conditions Possible coronary occlusion
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin R. Jenning, M.D.
Address Date signed

Q18836

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. Q18836

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 809 N. Durham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Anna M. Novotny

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1886

8. AGE: Years 60 | Months 6 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Frank Caruba

13. Birthplace Bohemia

MOTHER 14. Maiden Name Barbara Preana

15. Birthplace Bohemia

16 (a) Informant Joseph Caruba

(b) Address 809 N. Durham St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto Md

18 (a) Funeral director Frank Brockdorf & Son

(b) Address 900 N. Chester St

19 (a) FEB 21 1947 (Date rec'd by Local Registrar) (b) Registrar for Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2-20- 1947 at 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-15 1947 to 2-20 1947 and that I last saw h alive on 2/20 1947

| Immediate cause of death | Duration |
|---|---|
| Bronchial Pneumonia | |
| Due to bilateral | |
| Arterio-sclerosis | |
| Due to Heart disease | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1 for Hosp't. Date signed 2/20/47

X

G48837

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 309

Registered No. G48837

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1212 Holbrook St.
(c) Hospital or institution: 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 Holbrook St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Michael P. Dillman

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife Sophia M. Callender 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 9 | 8 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Penn. R.R.

FATHER
12. Name Not known
13. Birthplace Germany

MOTHER
14. Maiden Name Not known
15. Birthplace Germany

16 (a) Informant Wife
(b) Address 1212 Holbrook St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Clarence E. Hoffmann
(b) Address 1639 N. Broadway

19 (a) FEB 21 1947 (b) [illegible] Williamsport, Md.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/19 1947 at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/29 1946 to 2/19 1947.
and that I last saw h/he alive on 2/19 1947.

Immediate cause of death Pulmonary Thrombosis — Duration Sudden
Due to Cardiac Death Disease — 7
Due to
Other Conditions Contusion of Chest — 2
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph L. Blum M.D.
Address 1206 E. Fredrick Date signed 2/20/47

VS 150

G48838

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. G48838

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2708 W. North Ave.
(c) Hospital or institution: 15th

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2708 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** AMANDA ELIZABETH JONES

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | no |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | widow |

6 (b) Name of husband or wife Edward Augustus Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 6 | 13 | hr. min. |

9. Birthplace Carroll Co., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Green
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Edna Poe
(b) Address 1919 Forest Park Ave.

17 (a) Burial (b) Date thereof 2/21/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Oakland, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 21 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18, 1947 at 4:35P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 16, 1947 to Feb. 18, 1947 and that I last saw her alive on Feb. 17, 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral hemorrhage & paralysis | 3 days |
| Due to Advanced arterio-sclerosis | ? |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 2720 Hanover Blvd Date signed 2/20/47

VS 150

G18839

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

937

Registered No. G18839

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution:
Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County A. A. Co.
(c) City or town Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** JOHN BURGESS

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 8 | 16 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Camp Director
11. Industry or business

FATHER
12. Name Owen D. Burgess
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Cornellia Bond
15. Birthplace St. Mary's Co., Md.

16 (a) Informant Mr. H. Monroe Helm
(b) Address Pasadena, P. O., Md.

17 (a) Burial (b) Date thereof 2/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) FEB 21 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 May 1946 to 19 Feb 1947, and that I last saw him alive on 19 Feb 1947

| Immediate cause of death | Duration |
|---|---|
| Coronary occlusion, acute massive | |
| Due to Coronary arteriosclerosis | ? Years |
| Due to Chronic Myocarditis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph E. Muse Jr M. D.
Address 3311 St Paul St Balto. 18 Md Date signed 2/20/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48840

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46E

Registered No. G48840

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2937 Westwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2937 Westwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARIE E. DAUGHTON

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | no |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | white | Married |

6 (b) Name of husband or wife Albert E. Daughton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 11, 1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 1 | 8 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Frederick Krauk
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Bertha Kaiser
15. Birthplace Germany

16 (a) Informant Mrs. Albert E. Daughton
(b) Address 2937 Westwood Ave.

17 (a) Burial (b) Date thereof 2/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 FEB 21 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19, 1947, at 10:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945, to Feb. 19 1947, and that I last saw her alive on Feb. 15 1947.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma Intestinal obstruction | 6 mos. |
| Due to Carcinoma of colon | 1 mo. |
| Due to | 2 yr. |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation June 1946.
Major findings of operation: Carcinoma of colon
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robt. B. Wright M. D.
Address Medical Arts Bldg. Date signed 2/20/47.

VS 190

G18841

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

61

Registered No. G18841

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Linden & Madeira Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1733 N. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Margaret Yingling

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife: John R. Yingling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 12, 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 10 | 7 | hr. min. |

9. Birthplace: Howard County, Md.
(Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Elias Smallwood
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mary C. Harriman
15. Birthplace: Md.

16 (a) Informant: Mr. John R. Yingling
(b) Address: 1733 N. Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/47 (month) (day) (year)
(c) Cemetery or crematory: Trinity-Phiefers's Corner
Location: Howard County, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 FEB 21 1947 Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 19th 1947, at 7:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/16/ 1947 to 2/19/ 1947 and that I last saw her alive on 2/19/ 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure | |
| Due to Generalized arteriosclerosis Arteriosclerotic disease | 33 days |
| Due to Gangrene R foot (left foot) due to Diabetes mellitus | |
| Other Conditions Left middle thigh amputation | |

(Include pregnancy within 3 months of death)
Date of operation 11/26/47
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Gonzalez
Address Maryland G. Hospital Date signed 2/19/47 (M.D.)

X

G18842 BCH G60886 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 157E G18842

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address W. Fayette.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Lutherville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Raymond R. Stewart
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 | 1 | 46

8. AGE: Years 0 | Months 3 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore City Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Raymond Stewart
13. Birthplace Balto. Co. Md.

MOTHER 14. Maiden Name Fay Blevins.
15. Birthplace W. Va. Virginia

16 (a) Informant Raymond Stewart
(b) Address Lutherville Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-47 (month) (day) (year)
(c) Cemetery or crematory Jessup Cathedral
Location Jessup, Md.

18 (a) Funeral director London W. Brooks
(b) Address Govans, Md.

FEB 21 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 1947, at 9 45/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 20 1947, to Feb. 21 1947, and that I last saw him alive on Feb. 21 1947.

Immediate cause of death Congenital Heart (Type of malformation) — Duration 4 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E. Farber M. D.
Address Bon Secours Hosp., Balto. Date signed 2-21-47

VS 280

Birth Certificate

G48843 G-71341

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

G48843 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3600 Fifth St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Boy | White | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | 15 hr. 40 min. |

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Cecil Brown
13. Birthplace Texas

MOTHER
14. Maiden Name Doris Bryant
15. Birthplace Maryland

16 (a) Informant Mr. Cecil Brown
(b) Address 3600 Fifth St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-47 (month) (day) (year)
(c) Cemetery or crematory Mon Rovers
Location Belair Highway

18 (a) Funeral director Elizabeth Waterman
(b) Address 115 E. 21st St.

19 (a) Date received by registrar FEB 21 1947 (b) Signature for Willis Bothe, M.D.

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 2/21 1947, at 12:30 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2/20 1947 to 2/21 1947 and that I last saw him alive on 2/21 1947.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Prematurity, 6½ months | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation none performed
Major findings of operation:
of autopsy none performed

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature Herbert J. Lincks, M.D.
Address St. Agnes Hospital Date signed 2/27/47

G48814

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 162 B

Registered No. G48814

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland Homewood Apts.
(b) Street address Charles & 31st Sts.
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) -----
(e) Length of stay in Baltimore (yrs., mos., or days) 17

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County ----------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Charles and 31st. Sts.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ----------

**3 (a) FULL NAME** Loretta L. Hall

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| ---------- | ---------- |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband George G. Hall
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) May 12, 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 9 | 7 | --- hr. --- min. |

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business ----------

FATHER
12. Name John F. LeBrou
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth M. Aitken
15. Birthplace Baltimore, Md.

16 (a) Informant Samuel R. Mears
(b) Address 805 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/47 (month) (day) (year)
(c) Cemetery New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert St.

19 (a) FEB 21 1947 (Date received by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20 1947, at 6 P M

21. I certify that death occurred on the date above stated: that I attended deceased from Sept 1 1946, to Feb. 20 1947 and that I last saw h[illegible] alive on Feb. 19 1947.

| Immediate cause of death | Duration |
|---|---|
| (a) Senility | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles R. Goodwin M. D.
Address 1923 St Paul St Date signed 2/21/47

G48845

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

61

G48845 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + 33rd Sts
(c) Hospital or institution:
Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 208 W. Pennsylvania Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GREEN, JAMES ELLIS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | S |

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-22-1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 2 3 | — 27 | hr. min. |

9. Birthplace IRELAND
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name James Ellis Green
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Jane
15. Birthplace Ireland

16 (a) Informant Miss Jeanette Green
(b) Address Towson, Maryland

17 (a) Burial (b) Date thereof 2/22/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Govan Presbyterian
Location Baltimore, Md

18 (a) Funeral director H. W. Meeks and Son
(b) Address 805 N. Calvert St.

19 Filed by registrar FEB 21 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/19 1947 at 8:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/11a 1947 to 2/19 1947, and that I last saw him alive on 2/19 1947.

Immediate cause of death Bronchopneumonia — Duration 4 days

Due to Flu

Due to

Other Conditions Tuberculosis Quiet Airways - Diabetes

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Leuthauer M.D.
Address Union Mem. Hosp. Date signed 2/19/47

VS 150

107

G48816 BC# G 59813 GARY D. BURRIER ✓ 1190

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G48816

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address ~~3627 Elm Ave #11~~
(c) Hospital or institution: Maryland General Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3627 Elm Ave #11
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Gary D. Burrier ✓

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| — | — |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 4 | 2 | hr. min. |

9. Birthplace Baltimore, Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Nene.
11. Industry or business

FATHER
12. Name Clayton Burrier
13. Birthplace Maryland

MOTHER
14. Maiden Name Charlotte Hamilton
15. Birthplace Maryland

16 (a) Informant Clayton A. Burrier
(b) Address 3627 Elm Avenue

17 (a) Burial (b) Date thereof Feb. 22-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) FEB 21 1947 (b) Huntington Williams M.D.
(Date received by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 19 1947, at 5:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 18 1947 to Feb 19 1947 and that I last saw him alive on Feb. 19 1947.

| Immediate cause of death | Duration |
|---|---|
| Acute Enteritis | |
| Due to | |
| Due to | |
| Other Conditions Acidosis & de. hydration, diarrhea | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Burkhart M. D.
Address Md. Gen'l Hospital Date signed Feb. 19, 1947

VS 180

X

G48817

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G48817 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home + Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 856 Abbott Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Mr. Frank C Burnside

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mrs Cora Burnside

6 (c) If alive, give age (about) ? years

7. Birth date of deceased (mo., day, yr.) Sept 24 1865.

8. AGE: Years 81 | Months 5 | Days 0 | If less than one day ..... hr. ..... min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual Occupation Artist

11. Industry or business Retired

FATHER 12. Name Wm C Burnside

13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Matilda Leonard

15. Birthplace ?

16 (a) Informant Mrs Cora Burnside

(b) Address 856 Abbott Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 24 1947 (month) (day) (year)

(c) Cemetery or crematory Rodgers Location Seaford Del.

18 (a) Funeral director Frank Della Rocca

(b) Address 52 N. Monroe St

FEB 21 1947 (Date rec'd by registrar) (By) Huntington Williams M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1947, at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17 1947 to Feb 21 1947 and that I last saw him alive on Feb 20 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage. | 4 days |
| Due to Arteriosclerosis general. | 20 yrs |
| Due to Diabetes mellitus. | 20 yrs. |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation None.

Major findings of operation: —

of autopsy: None.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature David Rachanard. M. D.

Address Church Home + Hosp Date signed 2/21/47

X

G48848

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 95a

Registered No. G48848

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 726 W. Cross St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 726 W. Cross St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Laura Morgan

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife William Morgan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 25-

8. AGE: Years 65 | Months - | Days 25 | If less than one day hr. min. 82

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Hayslup
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Sophia Fontz
15. Birthplace Baltimore, Md

16 (a) Informant William Hepple
(b) Address 726 W. Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) (Signature of registrar) Huntington Williams M.D.
(b) Date received 2-23-1947

VS 250

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb. 19 1947 at 12 M

**21.** I certify that death occurred on the date above stated; that I attended deceased from June 15 1946 to Feb 19 1947 and that I last saw h alive on 19

Immediate cause of death Acute Dilatation — Duration 7 yrs

Due to Arteriosclerosis — 7 yrs

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature M. D.
Address 5 Duke St. Date signed 2-23-47

G48819

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

937

Registered No. G48819

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3717 Second St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3717 Second St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Emma E. Harwood
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife [illegible]
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23 1856

8. AGE: Years 90 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Spraunaur
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Speight
15. Birthplace Baltimore Md.

16 (a) Informant Daisy D. Goldsboro
(b) Address 3717 Second St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Flynn & Spraunaur
(b) Address 1416 Eutaw St.

19 (a) (Date received by Registrar) FEB 21 1947 (b) Huntington Williams, M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Febr. 20, 1947, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 26 1947 to Febr. 20 1947, and that I last saw h[illegible] alive on Febr. 20 1947.

Immediate cause of death Heart fibrillation — Duration: Several years

Due to myodegeneration cor dis — Duration: years

Due to Sclerosis of the coronary Arteries & high blood pressure

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Neubauer M. D.
Address 914 Patapsco Ave. Date signed 2-21-47

X

G48850

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G18850

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1844 W. Pratt St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1844 W. Pratt St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) **FULL NAME** William J. Downey

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| MALE | WHITE | DIVORCED. |

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19- 1864

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | 8 | 2 | hr. min. |

9. Birthplace Rock Hall Kent Co MD (Town, county, and state)

10. Usual Occupation WATERMAN

11. Industry or business " "

FATHER 12. Name JOSEPH DOWNEY

13. Birthplace KENT Co MD

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Helen E. Perry

(b) Address 1844 Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23-47 (month) (day) (year)

(c) Cemetery or crematory Wesley Chapel

Location Rock Hall Md

18 (a) Funeral director Edgar F. Lane

(b) Address Chestertown Md

FEB 22 1947 (Date rec'd by registrar) (b) Huntingtown Williams, Md

VS 150

## MEDICAL CERTIFICATION

20. **DATE OF DEATH** 2-21- 1947 at 6:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-19- 1947, to 2-21- 1947, and that I last saw him alive on 2-21- 1947.

| Immediate cause of death | Duration |
|---|---|
| Arteriosclerotic heart disease | ? |
| Due to Generalized arteriosclerosis | ? |
| Due to age | |
| Other Conditions — | |

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury —

23. Signature Morris B. Schreeder M. D. M. D.

Address 541 Fulton Ave. Date signed 2-21-47

X

G48851

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48B

Registered No. G48851

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1115 N. Luzerne Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 N. Luzerne Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HELENE MARIE LIEDER

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frederick L. Lieder
6 (c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): Mar. 4, 1908

8. AGE: Years: 38 | Months: 11 | Days: 14 | If less than one day: 5 hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Frederick Smith
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Mary Appel
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mr. Frederick L. Lieder
(b) Address: 1115 N. Luzerne Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2/22/47 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) FEB 22 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: February 19, 1947, at 8.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1946 to Feb. 19 1947 and that I last saw her alive on Feb 11 1946.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of uterus with Undetermined metastases | 1 yr. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: S. Karl Grossman M.D.
Address 1212 N. Baltimore Date signed 2/21/47
5th ave

VS 150

G48852

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G48852 55E

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7100 Rich hill Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** (MADALYN A. BOLARD) Madalyn A Bolard

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife: Rudolph F. Bolard
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Dec. 25 ~~1908~~ 1907

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 39 | 1 | 25 | hr. min. |

9. Birthplace Wilmington, Delaware
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George H. Beauchamp
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Annie E. Linthicum
15. Birthplace Delaware

16 (a) Informant Rudolph F. Bolard Jr.
(b) Address 7100 Rich Hill Road

17 (a) Burial (b) Date thereof 2/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address Baltimore Md.

19 (a) FEB 22 1947 Huntington Mills Assistant M.E.
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/19 1947 at 10 45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to h.s.c death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pelvic Endometriosis c malignant degeneration
Due to
Other Conditions Hypertensive C.V disease c acute cardiac failure
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury 2/9/47 at 10 45 A.M.
(b) Where did injury occur? Bon Secours Hospital
(c) Did injury occur at home, on farm, industrial place, in public place? Hospital While at work? No
(d) Means of injury Bed or operating table

23. Signature C.F. Southmayd M.D.
Medical Examiner.
Date signed 2/19/47

VS 151

Please write the causes of death clearly and legibly. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write

G48853

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G48853

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2903 Inglewood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2903 Inglewood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** PHILIP KOERBER

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| NO | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Lena, Katherine Koerber
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1897

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 49 | 5 | 20 | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Clerk, Post Office
11. Industry or business U S. Govt.

FATHER
12. Name Philip Koerber
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Amelia Schmidt
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Lena K. Koerber
(b) Address 2903 Inglewood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) FEB 22 1947 (Date Rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

**MEDICAL CERTIFICATION** AM

20. DATE OF DEATH February 21 1947, at 2.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946, to 2-21 1947
I last saw him alive on 2/7 1947

| Immediate cause of death | Duration |
|---|---|
| CORONARY OCCLUSION | 5 MIN. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature K. A. McCleary (for John F. Lemmon) LOCUM TENENS
Address 5103 HARFORD Date signed 2/21/47

X

G48851

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 90 B

Registered No. G48854

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the cause of death clearly and legibly. Physicians: please write correct age in especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 656 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Eugene D. Long

3 (b) If veteran, name war — 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~ |
|---|---|---|
| Male | White | Married |

6 (b) Name of ~~husband or~~ wife Mary Ella Long
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15th 1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 8 | 5 | hr. min. |

9. Birthplace Christianburg Va.
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Building

FATHER
12. Name William E. Long
13. Birthplace Va

MOTHER
14. Maiden Name Mary E. (Unknown)
15. Birthplace Va.

16 (a) Informant Mary Ella Long
(b) Address 656 W. Fayette St.

17 (a) Removal (b) Date thereof 2/22/47
(~~Burial, cremation,~~ or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Christiansburg
Location Va.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 E. Paul St.

19 (a) FEB 22 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VE 180

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/20 1947, at 2:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/20 1947 to 2/20 1947, and that I last saw him alive on 2/20 1947.

Immediate cause of death Myocardial failure — Duration 1 day
Due to Adhesive Pericarditis — years
Due to
Other Conditions Arterial Embolism rt. leg
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Adhesive Pericarditis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. Hamilton Smith
Address Franklin Sq. Hosp. Date signed 2/21/47

G48855 T.9121 BALTIMORE CITY HEALTH DEPARTMENT G48855
# CERTIFICATE OF DEATH 1860
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3620 Parkdale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Leroy E. Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Divorced |

6 (b) Name of husband or wife Helen Harris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 28th 1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 2 | 22 | hr. min. |

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Attendant
11. Industry or business Sinai Hospital

FATHER
12. Name William D. Harris
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Cora Helms
15. Birthplace Balto. Co. Md.

16 (a) Informant William E. Harris
(b) Address 3620 Parkdale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ St. Paul's
Location Arcadia, Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) FEB 22 1947 (Date rec'd by registrar) (f) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 20 1947, at 8:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/12 1947 to 2/20 1947, and that I last saw him alive on 2/20 1947.

| Immediate cause of death | Duration |
|---|---|
| Subarachnoid Hemorrhage & Brain Damage | |
| Due to Fracture of Skull | |
| Due to Epilepsy (Fall) | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 2/17/47
Major findings of operation: Fracture of brain & Subarachnoid hemorrhage
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 7/5
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 2/12/47 at 2:00 M
(c) Where did injury occur? Sinai Hospital (City or town) Balto. (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Sinai Hosp. (Specify type of place) While at work? Yes
(e) Means of injury? Fall - struck head on radiator

23. Signature Samuel D. Gabby M.D.
Address Sinai Hosp. Date signed 2/24/47

V S 150

For Wm. S. Helfrich, by Howard L. Mercer, M.D. X

G48856

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. G48856

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1801 Linden Ave
(c) Hospital or institution: at Home 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1801 Linden Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Henry Fink

3 (b) If veteran, name war — No —

3 (c) Social Security Account No. 217-09-2426

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna L. Fink

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) December 1873

8. AGE: Years abt 73 | Months 2 | Days ? | If less than one day — hr. — min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation employed Car Insul.

11. Industry or business Railroad.

FATHER
12. Name Henry Fink
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name — ? — ? — ? —
15. Birthplace Balto. Md.

16 (a) Informant Mrs Anna L. Fink (wife)
(b) Address 1801 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 24/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Stuart Moore Co.
(b) Address 1081 Main

19 (a) FEB 22 1947 (Date rec'd by registrar) (b) Huntingtown Williams, Md

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20th 1947, at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1946 to Feb 1947 and that I last saw him alive on Feb 19th 1947.

| | Duration |
|---|---|
| Immediate cause of death: Arteriosclerotic Cardiovascular renal disease | several years. |
| Due to: | |
| Due to: | |
| Other Conditions: Hypertension, Nephritis, chronic, with Generalized Arteriosclerosis | |

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence L. Kerwin M.D.

Address 1938 Linden Ave Date signed 21 Feb 47

VS 150

G18857

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48B

Registered No. G48857

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hospital Baltimore, Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 25 E. 21st St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Nanon Haldeman

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Separated |

6 (b) Name of husband or wife Bert Haldeman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 9 | 10 | hr. min. |

9. Birthplace Illinois (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Rev. G. H. Sheldrake
13. Birthplace unknown

MOTHER
14. Maiden Name Edna Unknown
15. Birthplace unknown

16 (a) Informant Miss Lena Carey
(b) Address 2107 Lovegrove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (d) FEB 22 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20, 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/18/1947 to 2/20/1947 and that I last saw her alive on 2/20/1947

Immediate cause of death Respiratory Failure — Duration
Due to Generalized Pneumonia
Due to Adeno-Carcinoma of Uterus
Other Conditions Intestinal Obstruction
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. C. Ley H. Wilson M. D.
Address University Hospital Baltimore, Md. Date signed 2/20/47

VS 150

G48858

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G48858

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5528 Rusk Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** GARABED G. HEGHINIAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Jeannette M. Heghinian
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, ~~1870~~ 1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| ~~77~~ 76 | 1 | 19 | hr. min. |

9. Birthplace Armenia (Town, county, and state)
10. Usual Occupation Civil & Mech. Eng. (retired)
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mrs. Garabed G. Heghinian
(b) Address 5528 Rusk Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 FEB 22 1947 (Date received by Registrar) (b) Wilmington for Wilmington, Del.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/20 1947, at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6 1947 to 2/20 1947 and that I last saw him alive on 2/20 1947.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Cardiac failure | |
| Due to Coronary thrombosis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Someray Nichols Jr. M. D.
Address Univ. Hosp. Date signed 2/24/47

VS 150

G48859

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

131a

Registered No. G48859

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2308 Rosedale St.
(c) Hospital or institution:

15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2308 Rosedale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** GEORGE WASHINGTON ABRAHAM

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Adeline L. Abraham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1859

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 88 | 1 | 12 | hr. min. |

9. Birthplace Washington, D. C. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Building Business

FATHER
12. Name George Francis Abraham
13. Birthplace England

MOTHER
14. Maiden Name Susan Partridge
15. Birthplace England

16 (a) Informant Mrs. Adeline L. Abraham
(b) Address 2308 Rosedale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) FEB 22 1947 (Date rec'd by registrar) (b) Lexington Hill

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 20, 19 47 at 1:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 19 47 to Feb 20 19 47.
and that I last saw h alive on Feb 19 19 47.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Accident | |
| Chronic Nephritis | |
| Chronic Myocarditis | |
| Due to Generalized Arteriosclerosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos J Abbott
Address 4509 Liberty Heights Date signed 2-21

VS 150

X

G48860

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 43B

Registered No. G48860

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 322 E. 25th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 322 E. 25th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** CHARLES F. EICKER

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | 717-07-7449 |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Daisy E. Eicker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 9 | 12 | hr. min. |

9. Birthplace York Co., Pa. (Town, county, and state)
10. Usual Occupation Retired Dispatcher
11. Industry or business Penna. R. R.

FATHER
12. Name John Eicker
13. Birthplace Germany

MOTHER
14. Maiden Name Helen Bink
15. Birthplace Pa.

16 (a) Informant Mrs. Daisy E. Eicker
(b) Address 322 E. 25th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) FEB 22 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 20, 1947 at 8:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1941 to Feb 20 1947, and that I last saw h.. alive on Feb 19 1947

| | Duration |
|---|---|
| Immediate cause of death: cerebral thrombosis | 2 days |
| Due to: arteriosclerosis. | 1 year |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert K. Mortimer Jr M. D.
Address 2706 St Paul St Date signed 2/21/47

VS 190

G48861

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G48861

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 700 W 40th St
(c) Hospital or institution:
Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 237 W Hamilton St
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

**3 (a) FULL NAME** Crane, Mrs Emily Levering

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F. | W. | W. |

6 (b) Name of husband or wife William C. Crane
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug-28-1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 5 | 24 | hr. min. |

9. Birthplace Volcano W. Va
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER 12. Name Lawrason Leeering
13. Birthplace Balto - Md -

MOTHER 14. Maiden Name Lilly Street
15. Birthplace Balto Md —

16 (a) Informant Home for Incurables Rec'd
(b) Address 700 W 40th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 22 1947 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem
Location Pikesville Md

18 (a) Funeral director E W Parnham
(b) Address 510 Fidelity Howard Ave

19 (a) FEB 22 1947 (Date rec'd by registrar) [illegible] Registrar

VS 8

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 20 1947 at 1:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/26 1946 to 2/20 1947
and that I last saw him alive on 2/20 1947
Immediate cause of death Cerebral Vascular Accident — Duration 3 Days
Due to Arteriosclerosis Generalized & Hypertensive Cardiac Disease — 8 Years
Due to [illegible]
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Hopkinson Hershey M.D.
Address 214 Medical Arts Bldg Date signed 2/20/47

G48862 #89363

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1316

Registered No. G48862

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2654 Kirk Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Veronica Talinowska

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Boleslaw
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 51 | Months | Days | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Johny Lobus
13. Birthplace Poland

MOTHER 14. Maiden Name Mary Rusin
15. Birthplace Poland

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-47 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem
Location Balto. County

18 (a) Funeral director Mrs. Mary Welby
(b) Address 401 E. Chester Street

19 (a) FEB 22 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb 20 1947, at 2 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec 11 1946 to Feb 20 1947 and that I last saw h[illegible] alive on Feb 20 1947.

| | Duration |
|---|---|
| Immediate cause of death Uremia | |
| Due to chronic glomerulo-nephritis, nephrotic stage | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert C. Austrian M.D.
Address Johns Hopkins Hosp. Date signed 20 Feb 47

G48863

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83B

Registered No. G48863

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 d
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6723 Graceland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** LENA ROSE (RUSTEJKO)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced? Married

6 (b) Name of husband or wife Andrew

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Martin Cimanski

13. Birthplace Poland

MOTHER 14. Maiden Name Mary Jarzbiewicz

15. Birthplace Poland

16 (a) Informant Andrew Rose Rustejko

(b) Address 6723 Graceland Ave Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-21-47 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem

Location Baltimore County

18 (a) Funeral director John Mc Weber

(b) Address 402 E Chester St

19 (a) FEB 20 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 190

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2-19-1947, at 12:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-14 1947 to 2-19 1947 and that I last saw h[illegible] alive on 2-18 1947.

Immediate cause of death Cerebral Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 2/19/47

G18864 BC# G68837 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 159 Registered No. G18864

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Caton and Wilkens Ave
(c) Hospital or institution: St Agnes Hospital W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2750 Wilkens Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Baby Boy Dorsey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25-1947

8. AGE: Years | Months | Days: 1 day 28 | If less than one day: hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Charles H. Dorsey
13. Birthplace Md.

MOTHER 14. Maiden Name Clara Gibbs
15. Birthplace Maryland

16 (a) Informant (Hospital)
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-22-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md

18 (a) Funeral director George A. Farley
(b) Address Fulton & Fayette Sts

FEB 22 1947 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 2/21 1947, at 2 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 1/24 1947, to 2/21 1947 and that I last saw h[illegible] alive on 2/21 1947

Immediate cause of death: Marasmus

Due to Prematurity, 3 lbs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert J. Lenhos
Address St Agnes Hosp Date signed 2/24/47

VS 150

G48865

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1316

Registered No. G48865

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians:—please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 605 N Calhoun St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Henry P. Woods

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | negro | married |

6 (b) Name of husband or wife Martha Woods
6 (c) If alive, give age, years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1901

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 yrs. | 1 | 3 | hr. min. |

9. Birthplace Md (Town, county, and State)
10. Usual Occupation Dish Washer
11. Industry or business

FATHER — 12. Name Peter Woods
13. Birthplace Laurel Md.

MOTHER — 14. Maiden Name Mary Dorsey
15. Birthplace Md.

16 (a) Informant Robert Woods (son)
(b) Address 635 N. Calhoun

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 24 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location

18 (a) Funeral director Wm Katie R. Williams
(b) Address 322 N. Calhoun St.

19 (a) Filed FEB 22 1947 (Date) (b) Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-19-1947 19..., at 8:45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-19 1947 to 19..., and that I last saw h.M alive on 2-19 19 47

| Immediate cause of death | Duration |
|---|---|
| Left heart failure | |
| Due to Hypertension & Arteriosclerosis C-V disease | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy Chronic Nephrosclerosis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. Southwick M. D.
Address Franklin Sq. Hosp Date signed 2/24/47

G48866

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1243

Registered No. G48866

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland.
(b) Street address 1611 Lexington St.
(c) Hospital or institution: (10)
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Margaret Hawthorne

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Colored | Married |

6 (b) Name of husband or wife William Hawthorne

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1901

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 45 | 7 | | hr. min. |

9. Birthplace Chester Co. Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant William Hawthorne
(b) Address 1611 W. Lexington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 22. 1947 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Hattie R. Williams
(b) Address 322 N Schroeder St

19 (a) 2/22/47 (Date rec'd by registrar) (b) Registrar

VS 191

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 18 1947 at 5:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hypertrophy & acute dilatation of heart; Coronary disease; Edema and congestion of lungs; Early fibrosis of liver; Nephrosclerosis; Generalized atherosclerosis; Hydrothorax; Hydrops

Other Conditions gastritis, chronic (acute); Chronic pelvic disease; Fibroid uterus
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walpert M.D.
Medical Examiner.
Date signed 2-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48867

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

50

Registered No. G48867

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 6339 N. Carrollton ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6339 N. Carrollton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Caroline Biggers Pratt

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Col. | Married |

6 (b) Name of husband or wife Thomas Pratt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1906

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 40 | 8 | 18 | hr. min. |

9. Birthplace Harford Co. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Reno Biggers
13. Birthplace Md.

MOTHER
14. Maiden Name Rose Gardner
15. Birthplace Harford Co. Md.

16 (a) Informant Lillian Culbreth
(b) Address 2259 N. Carey St.

17 (a) Burial (b) Date thereof Feb. 22, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) FEB 22 1947 (b)
(Date rec'd by registrar) Registrar

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 2/19 1947, at 12 p M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/13 1947 to 2/19 1947.
and that I last saw h[illegible] alive on 2/19 1947.

| Immediate cause of death | Duration |
|---|---|
| Carcinomatosis of Omentum | 6 mos. |
| Due to Metastasis, | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. V. Jackson M. D.
Address 1600 Washington Date signed 2/21/47

PURVIS

G48868

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48B

Registered No. G48868

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2089 N. Carey St.
(c) Hospital or institution: [illegible] 19

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) Country
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2089 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lillie Purvis

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Col. | Married |

6 (b) Name of husband or wife James Purvis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | 9 | 6 | hr. min. |

9. Birthplace Colemans Falls Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Wilson Brown

13. Birthplace Colemans Falls, Va.

MOTHER 14. Maiden Name Mary Sadler

15. Birthplace Va

16 (a) Informant James Purvis

(b) Address 208 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 22 1947 (month) (day) (year)

(c) Cemetery or crematory Colemans Falls Va

Location

18 (a) Funeral director Mrs Katie R Williams

(b) Address 324 N. Schroeder St.

19 (a) FEB 22 1947 (b) Huntington Williams Registrar
(Date rec'd by registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 19 1947 at 3:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 14 1947 to Feb. 19 1947 and that I last saw h[illegible] alive on Feb. 18 1947

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 hr.

Due to: Hypertension

Cardio-Vascular disease — 2

Due to

Other Conditions: Carcinoma of uterus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Walter Sherrington M. D.

Address 201 N Carey St Date signed 2/22/47

G18869
AB-63307

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

93D

G48869
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6yrs- 13days
(e) Length of stay in Baltimore (yrs., mos., or days) 6yrs.13days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County 12
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillion Kline

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~9-9-~~ Apr-9, 1876

8. AGE: Years 70 | Months 10 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Luther Babblon
13. Birthplace ?

MOTHER
14. Maiden Name Lena ?
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 22 47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave

18 (a) Funeral director L. Hemsmath & Daughters
(b) Address 2415-17 Eastern Ave.

19 (a) FEB 22 1947 (b) (Date rec'd by registrar) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19- 1947, at 11 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-6- 1941, to 2-19- 1947, and that I last saw h ~~er~~ alive on 2-19- 1947

| Immediate cause of death | Duration |
|---|---|
| Circulatory Failure | |
| Due to Arteriosclerotic Heart Disease | |
| Other Conditions Erysipelas | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. R. Vanborough M. D.
Address Date signed

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

KELLEY R

G48870

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 181

Registered No. G48870

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital -
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County ~~Balt~~
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 522 E 21ST ST.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs. Millard R. Kelley

3 (b) If veteran, name war

3 (c) Social Security Account No. V

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Divorced |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 10 | 13 | hr. min. |

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER
12. Name Wm. H. Kelley.
13. Birthplace Md.

MOTHER
14. Maiden Name Mary L Banek.
15. Birthplace Md.

16 (a) Informant Wm. E. Kelley
(b) Address 518 E. 23rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 22, 1947 (month) (day) (year)
(c) Cemetery or crematory St. Marys
Location Wampoleum

18 (a) Funeral director Lemmerth and Donovan.
(b) Address 2615-11 Lieutenant Ave.

19 (a) (b) Huntington Williams, M.D.
(Date received by registrar) FEB 22 1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/20 1947, at 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11/ 1947 to 2/20 1947 and that I last saw h/m alive on 2/20 1947

| Immediate cause of death | Duration |
|---|---|
| Cardio-Respiratory failure | |
| Due to Pneumonia - bilateral - | |
| Due to 3rd burns - extensive - body | |
| Other conditions Chronic Alcoholism - Delirium Tremens | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 9/8
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 1-10-47 at 11 P. M.
(c) Where did injury occur? Baltimore, Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? NO
(Specify type of place)
(e) Means of injury Smoking in bed.

23. Signature Howard J. Owens

Address St Josephs Date signed 2-21-47

Howard J. Owens, M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. If correct age is especially important.

C48871

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. C18871

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1638 Belt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1638 Belt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary E. Tully

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | W |

6 (b) Name of husband or wife James C. Tully
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 16 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 3 2 | 4 | hr. min. |

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation At Home.
11. Industry or business

FATHER 12. Name Michael Scheiner
13. Birthplace Baltimore

MOTHER 14. Maiden Name Mary Stafford
15. Birthplace Baltimore

16 (a) Informant Mary Bosel
(b) Address 1631 Belt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 24 1947 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Old Fairmount Rd

18 (a) Funeral director Peter F. Duffy Son
(b) Address Loreland & Annapolis Rd

19 (a) FEB 22 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** February 20 1947 at 10:30 A.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from April 15 1945 to Feb 20 1947 and that I last saw h alive on 19

| Immediate cause of death | Duration |
|---|---|
| (a) Myocarditis | 2 yrs. |
| Due to (b) Arteriosclerosis & Cerebral Softening | 5 yrs. |
| Due to (c) | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury Fell from Stairs
23. Signature
Address 517 Addison St Date signed 2/21/47 M. D.

VS 150

G18872

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G18872

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland 703 Mura Street
(b) Street address ~~1717 E. Biddle St~~
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 Homewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Theresa E. Gordon

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Charles H. Gordon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1905

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 41 | 9 | 6 | hr. min. |

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Matron at C & P Telephone
11. Industry or business Co.

FATHER
12. Name John J. O'Connor
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Catherine M. Mears
15. Birthplace Ireland

16 (a) Informant Mr. Charles H. Gordon
(b) Address 1017 Homewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 24/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location 4300 Old Frederick Rd

18 (a) Funeral director Edgar H. Carpenter Son
(b) Address 924 E. Eager St.

FEB 22 1947 (b) Huntington Wilt Registrar
(Date rec'd by Local Registrar)

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb. 19, 1947, at 11:30 AM

**21.** I certify that death occurred on the date above stated; that I attended deceased from 19 to 2/17 1947 and that I last saw h(er) alive on 2/17 1947

| Immediate cause of death | Duration |
|---|---|
| (a) Acute Endocarditis dilatation | |
| Due to (b) Hypertension | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 733 Argonne Dr Date signed 2/21/47

G48873

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46

G48873
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4506 Sorento Ave.
(c) Hospital or institution: Colonial Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 weeks.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2735 Guilford Ave. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lenora Anna Allison

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife: James E. Allison
6 (c) If alive, give age 57 years
7. Birth date of deceased (mo., day, yr.) Nov. 8, 1883
8. AGE: Years 63 | Months 3 | Days 12 | If less than one day: hr. min.
9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Charles Siebert
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Charles F. Ransone
(b) Address 2735 Guilford Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.
18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave.
19 (a) 2 23 1947 (Date rec'd by registrar) (b) Washington Williams, M. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 20 1947, at 12:25 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 2/1/1947 to 2/20/1947, and that I last saw her alive on 2/20/1947.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Embolism | 1 hr. |
| Due to Coronary Thrombosis | 1 yr. |
| Due to Hemorrhage | |
| Due to | |
| Other Conditions Multiple Fibromyomata | |

(Include pregnancy within 3 months of death)
Date of operation 2/17/47
Major findings of operation: Ca Rectum
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Chas. Norton, Jr. M. D.
Address 1933 W. Baltimore Date signed 2/21/47

G48874 ✓ G48874

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2127 McHenry St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2127 McHenry St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** George Thiergartner

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Anna Thiergartner
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1863

8. AGE: Years 84 | Months — | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Germany (Town, county, and state or foreign country)
10. Usual Occupation Iron Cutter
11. Industry or business Retired

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant John A. Lehybert
(b) Address 1147 W. Hamburg St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-47 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director George L. Lohrwasser
(b) Address 2101 Frederick Ave. Transferred for Williamsport, Md.

23 1947 (Date received by registrar) Registrar

VS 180

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 21 1947; at 7:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 20 1946, to Feb. 21st 1947, and that I last saw him alive on 2-21-47. 19

| Immediate cause of death | Duration |
|---|---|
| Coronary embolism | 5 yrs + |
| Due to Arteriosclerosis advanced | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. E. Lantz M. D.
Address 642 Wash Blvd Date signed 2-22-47.

X

G48875

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 55a

Registered No. G48875

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Union Memorial Hosp.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles G. Amos

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W. | Single |

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 25, 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 6 7 | 25 | hr. min. |

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Hosp. Orderly
11. Industry or business

FATHER
12. Name Thomas Amos
13. Birthplace Virginia

MOTHER
14. Maiden Name Virginia Ward
15. Birthplace Virginia

16 (a) Informant Elmer P Amos
(b) Address Princess Anne Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 28 1947 (month) (day) (year)
(c) Cemetery or crematory Princess Anne Cem
Location Princess Anne
18 (a) Funeral director Charles Dashiell
(b) Address Princess Anne Somerset Co Md.
19 (a) (Date rec'd) (Registrar) Huntington Williams Md

FEB 25 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb - 22 - 1947, at 5 05 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Feb - 20 1947, to Feb - 22 1947, and that I last saw h[illegible] alive on Feb - 22 - 1947.

| Immediate cause of death | Duration |
|---|---|
| Pulm. Oedema | |
| Due to Metastasis from | |
| Due to Adrenal Tumor | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Adrenal Tumor, Rt

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature George H. Schlesinger
Address C. M H Date signed 2/26/47

X

G48876 BALTIMORE CITY HEALTH DEPARTMENT G48876
# CERTIFICATE OF DEATH 83a
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 413 Cedarcroft Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) /
(e) Length of stay in Baltimore (yrs., mos., or days) — mo

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Nej. (b) County
(c) City or town New York City (If outside city or town limits, write RURAL and give town)
(d) Street No. 305 West End Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Veronica Stanley
3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W. | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1/17/1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 1 | 4 | hr. min. |

9. Birthplace New York (town, county, and state)
10. Usual Occupation Stenographer
11. Industry or business
FATHER 12. Name Thomas Haney
13. Birthplace N.Y.
MOTHER 14. Maiden Name Sarah Bothwell
15. Birthplace N.Y.
16 (a) Informant Mrs James Reynolds
(b) Address 413 Cedarcroft Rd
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25/47 (month) (day) (year)
(c) Cemetery or crematory
Location New York City
18 (a) Funeral director J. J. Daley Sons
(b) Address 318 Light St.
19 (a) Filed 2/28/1947 (Date filed) (b) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**
20. DATE OF DEATH 2/21/1947, at 10 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 9/12/1946 to 2/21/1947 and that I last saw h alive on 2/21/1947.

| Immediate cause of death | Duration |
|---|---|
| Myocardial Insufficiency | 2 hrs |
| Due to Cerebral Hemorrhage | 48 hrs |
| Due to Cerebral Arteriosclerosis | 2 yrs |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thomas J Mack
Address 502 E 22nd St Date signed 2/27/47

VS 150

G48877

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G48877 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 136 Jackson Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 136 Jackson Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Kaplan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 72 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name unknown

13. Birthplace Russia

MOTHER 14. Maiden Name unknown

15. Birthplace Russia

16 (a) Informant Mrs William Raffel

(b) Address 2416 W Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-23-47 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Lewin Inc

(b) Address 1429 E Baltimore St

19 FEB 23 1947 (b) Registrar
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2-21-1947, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-17 1947 to 2-21 1947, and that I last saw h[illegible] alive on 2-17 1947.

Immediate cause of death acute Cardiac Dilatation — Duration

Due to acute Coronary Upset

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. C. Feldman

Address 1425 E Balto Date signed 2/24/47

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BCH BALTIMORE CITY HEALTH DEPARTMENT

G48878 G 70024 CERTIFICATE OF DEATH 157 G48878

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2313 Ruskin Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hess (Elsie Hess)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ✓

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 7 - 1947

8. AGE: Years | Months | Days: 13 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation ✓

11. Industry or business

FATHER 12. Name Kurt
13. Birthplace Germany

MOTHER 14. Maiden Name Liegel
15. Birthplace Germany

16 (a) Informant Kurt Hess
(b) Address 2313 Ruskin Ave

17 (a) Burial (b) Date thereof 2-23-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1420 E Baltimore St

19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 22 1947

V S 190

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 20 19 47 at 9'15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 19 47 to Feb 20 19 47 and that I last saw h live on Feb 20 19 47

| Immediate cause of death | Duration |
|---|---|
| Encephalocele | |
| Due to Congenital anomaly | |
| Due to | |
| Other Conditions Exploratory operation of encephalocele | |

(Include pregnancy within 3 months of death)

Date of operation 2-20-47

Major findings of operation: Encephalocele

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Francis J Michael M. D.

Address Sinai Hosp Date signed Feb 20 1947

X

G48879 BALTIMORE CITY HEALTH DEPARTMENT G48879

# CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Balto. (If outside city or town limits write RURAL and give town)
(d) Street No. 7113 Oxford St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** WILLIAM W. HAYES

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14-1888

8. AGE: Years 58 | Months 3 | Days 7 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Andrew Hayes
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Mary E. Stanton
15. Birthplace Balto. Md.

16 (a) Informant Mary E. Adams
(b) Address 228 E. University Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/47 (month) (day) (year)
(c) Cemetery or crematory Mem. Gdns.
Location Old Frederick Rd.

18 (a) Funeral director John S. Indan
(b) Address 4301 Greenmount Av.

19 (a) FEB 23 1947 (Date rec'd by registrar) Livingston Williams, M.D. Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 2/21 1947, at 9:45 AM

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2/11 1947, to 2/21 1947, and that I last saw him alive on 2/20 1947

| | Duration |
|---|---|
| Immediate cause of death GENERALIZED LYMPHOSARCOMA | 10 DAYS |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23. Signature** Charles W. Stewart, Jr. M. D.
Address MD. GEN. HOSPITAL Date signed 2/21/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully completed. Please write the causes of death clearly and legibly.

G48880

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G48880 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St. City
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3yrs 4mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** Wm. Bokee

3 (b) If veteran, name war

3 (c) Social Security Account No. single

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | white | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 2 | 6 | hr. min. |

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name William F. Bokee
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary Mc Grann
15. Birthplace Ireland

16 (a) Informant Little Sisters of the Poor
(b) Address Bow Valley & 1200 city

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 24, 1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wredefeld
(b) Address 900 E. Biddle St

19 (a) FEB 23 1947 (Date rec'd by registrar) (b) Signature for William Bokee

VS 3

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 21 1947, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1947, to Feb 21 1947, and that I last saw h alive on Feb 20 1947.

| Immediate cause of death | Duration |
|---|---|
| Edema Lungs | 2 day |
| Due to | |
| Due to Chronic Myocarditis | 5 yrs |
| Other Conditions Arteio-Sclerosis | 10 yrs |

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Ave Date signed 2/22/47

X

G48881

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G48881 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1311 Clarkson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Eugene Bach, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | W. |

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13-1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 (79) | 5 | 7 | hr. min. |

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Eugene Bach, Jr.
(b) Address 1424 Patapsco St.

17 (a) Burial (b) Date thereof 2/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Balto

18 (a) Funeral director Leonard J. Rusk
(b) Address 2305 Stanford Rd

19 (a) Huntington Williams M.D.
(Date rec'd by registrar) FEB 23 1947 Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 2-20- 1947, at 7:30 A. M

**21.** I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 2/22/47

VS 181

G48882 ✓ G48882

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 186a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 Ailsa Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine C. Marschall

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widow |

6 (b) Name of husband or wife Nicholas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-9-64

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 0 | 12 | hr. min. |

9. Birthplace New York (Town, county, and state)

10. Usual Occupation – at home

11. Industry or business –

FATHER 12. Name Adam Bahn
13. Birthplace New York

MOTHER 14. Maiden Name Emma Beech
15. Birthplace New York

16 (a) Informant Alfred N. Marschall
(b) Address 3602 Ailsa Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 (month) 26 (day) 47 (year)

(c) Cemetery or crematory Woodlawn
Location White Plains N.Y.

18 (a) Funeral director Leonard J. Keck
(b) Address 5305 Harford Road

19 (a) 2 2 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VE 186

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-21 1947 at 4:40A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-20 1947 to 2-21 1947 and that I last saw her alive on 2-21-1947.

| Immediate cause of death | Duration |
|---|---|
| Hypertensive Cardio Vascular Disease Bronchial Pneumonia | 10 yrs + 12 hrs |
| Due to | |
| Due to | |
| Other Conditions Hypertensive fracture of hip (Include pregnancy within 3 months of death) | |

Date of operation none
Major findings of operation:
of autopsy: none

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27
(a) Accident, suicide, or homicide accident at home
(b) Date of occurrence 2-20-47 at 9 A M
(c) Where did injury occur? Balto. Ailsa Ave
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? No
(Specify type of place)
(e) Means of injury slipped & fell

23. Signature Howard J. Bandage M.D.
M. D.
Address Franklin Sq Hosp Date signed 2-21-47

Howard J. Bandage, M.D.

G48883

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G48883 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every answer is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2636 Hampden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Wiland Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-14-5564

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife Pauline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 23-1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 9 | 29 28 | hr. min. |

9. Birthplace Balto- Md.
(Town, county and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER 12. Name John Wigland
13. Birthplace Germany

MOTHER 14. Maiden Name Catherine Kauffman
15. Birthplace Germany

16 (a) Informant Mrs. Pauline Wieland
(b) Address 2636 Hampden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Md

18 (a) Funeral director L. J. Rusk
(b) Address 5305 Harford Rd.

19 (a) FEB 23 1947 (Date received by Registrar) (b) Signature for Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 2/21 1947 at 10:25 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2-21 1947 to 2-21 1947, and that I last saw h. i. alive on 2-21 1947

Immediate cause of death Respiratory Coma — Duration

Due to Cerebral Cerebrovascular accident

Due to arteriosclerosis CVD

Other Conditions Appendicitis operation 1918

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature A. K. Crouch M. D.

Address Univ. Hosp. Date signed 2/24/47

Howard J. Mencken, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48884

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G48884 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3004 Chesley Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3004 Chesley Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Margaret M. Kraus

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Joseph G. Kraus
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | -- | 4 | hr. min. |

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: at home
11. Industry or business

FATHER
12. Name: Micholas Hoffmann
13. Birthplace: Frence

MOTHER
14. Maiden Name: Margaret A. Lang
15. Birthplace: Germany

16 (a) Informant: Mrs. Louise M. Angel
(b) Address: 3004 Chesley Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Baltimore

18 (a) Funeral director: Leonard J. Ruck
(b) Address: 530 Harford Road

19 Filed (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 27 1947, to Feb. 21 1947, and that I last saw her alive on Feb. 20 1947.

Immediate cause of death: Chronic myocarditis Acute congestive failure. — Duration: 6 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. J. Schmick M. D.
Address 701 N. Kenwood Ave. Date signed 2-22-47

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48885 / 94a

Registered No. G48885

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland — George Peckwood
(b) Street address — Hollyhood Rd
(c) Hospital or institution — University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 2
(e) Length of stay in Baltimore (yrs., mos., or days) — Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State — Md. (b) County — Baltimore
(c) City or town — Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. — 110 Upton Rd (If rural give location)
(e) Citizen of foreign country? — No (Yes or No)
If yes, name country —

**3 (a) FULL NAME** — Lillis F. Johnson (LILLIS FOWLER JOHNSON)

3 (b) If veteran, name war — none
3 (c) Social Security Account No. — none

Sex — Female | 5. Color or race — White | 6 (a) Single, married, widowed, or divorced. — Single

6 (b) Name of husband or wife — none
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) — about 1861 (6-15)

8. AGE: Years — abt 85 | Months — 8 | Days — 7 | If less than one day ____ hr. ____ min.

9. Birthplace — Baltimore Md.
(Town, county, and state)

10. Usual Occupation — none

11. Industry or business — none

FATHER
12. Name — Albert R. Johnson
13. Birthplace — Baltimore Md

MOTHER
14. Maiden Name — Miss Harrington
15. Birthplace — Baltimore Md

16 (a) Informant — Mrs Helen R. Douglas (Friend)
(b) Address — 110 Upton Rd - City-12.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 2-24-47 (month) (day) (year)
(c) Cemetery or crematory — Greenmount
Location — Baltimore - Md.

18 (a) Funeral director — Stewart & Company
(b) Address — 108 W North Ave.

19 (a) ____ (Date rec'd by registrar) (b) Harrington Miller M.D.

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** — 2/22 19 47 at 9:30 AM

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2/20 19 47 to 2/22 19 47 and that I last saw h. alive on 2/20 19 47.

| Immediate cause of death | Duration |
|---|---|
| Resp. failure | |
| Due to Cardiac failure | |
| Due to Coronary Thrombosis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature — Pomeroy Tucker Jr. M. D.
Address — University Hospital Date signed 2-22-47

X

AB-10817 648886

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 14

Registered No. 648886

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16days
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 112 W. Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Braxton

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | Married |

6 (b) Name of husband or wife Ella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24- 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 3 | 26 | hr. min. |

9. Birthplace Essex County, Va.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name William Braxton
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Proctor
15. Birthplace Virginia

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 23, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park.
Location Baltimore Co. Md.

18 (a) Funeral director Chas. H. Stallard
(b) Address 1631 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Washington Williams (Registrar)

B 23 1947
Vs 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 20- 1947, at 3.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-4- 1947 to 2-20- 1947 and that I last saw h 1m alive on 2-20- 1947.

| Immediate cause of death | Duration |
|---|---|
| Respiratory Failure | |
| Due to Tuberculosis of Brain, T. | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm R. Yearsley M. D.
Address Balto City Hosp Date signed 2-20-47

G48887

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G48887 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1810 N. Bond Street
(c) Hospital or institution: 8

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 N. Bond Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary M. Taylor

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| None | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11th, 1925

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 21 | 10 | 9 | ##### min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Richard J. Taylor
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Bilz
15. Birthplace Baltimore, Md.

16 (a) Informant Richard J. Taylor (Father)
(b) Address 1810 N. Bond Street

17 (a) Burial (b) Date thereof 2/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1745 Harford Avenue, Md.

FEB 22 1947 (b)
(Registrar's signature)
Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/20/47 19..., at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1947 to Feb 20 1947
and that I last saw h... alive on ... 19...

| | Duration |
|---|---|
| Immediate cause of death: Cerebral Hemorrhage | 2 hours |
| Due to: Hypertensive Cardio-Vascular Disease | |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Samuel Adolf
Address 1331 North Ave Date signed 2-27-47

V S 150

X

G48888

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G48888 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2019 Sinclair Lane
(c) Hospital or institution: 87
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2019 Sinclair Lane
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emma M. Quast

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Frank H. Quast

6 (c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.) Dec. 5th., 1865

8. AGE: Years 81 | Months 2 | Days 16 | If less than one day: ###### min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name William P. Flamm
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant George F. Quast
(b) Address 402 W. Forest View Rd. Linthicum Heights, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/47 (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location East end of North Ave. Baltimore

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) 2-3-1947 (Date received by registrar) (b) Huntington Willis Registrar

V S 190

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/21/47 19 ..., at 8-30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 22 1946 to Feb-21 1947 and that I last saw her alive on Feb-14- 1947

| Immediate cause of death | Duration |
|---|---|
| Pedmonary Embolus | 1 day |
| Due to Phlebitis RO Leg | 2 weeks |
| Due to | |
| Other Conditions Chronic Myocarditis | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Ave. Date signed 2/21/47

G48889

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 194a

G48889 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Avenue
(c) Hospital or institution: Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3229 Kenyon Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mrs. Mary Glenn

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Henry Glenn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 9 | 2 | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Domestic Servant
11. Industry or business

FATHER
12. Name John Klosemeier
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa
15. Birthplace Germany

16 (a) Informant Mrs. Helen MATACOTTA
(b) Address 1631 E. 29th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof FEB 24 47 (month) (day) (year)
(c) Cemetery or crematory TRINITY
Location O'DONNEL ST.

18 (a) Funeral director L. HEEMANN & SON
(b) Address 6867 HARFORD Rd.

19 (a) FEB 23 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-21 1947, at 11 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1 1946 to 2-21 1947 and that I last saw her alive on 2-21 1947

Immediate cause of death: Acute cardiac dilatation — Duration

Due to: Coronary arteriosclerosis

Due to:

Other Conditions: Bronchopneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry W. Stolges M. D.
Address Jenkins Mem. Hosp. Date signed 2-21-47

VS 150

G48890

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1147

G48890
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 432 N. Gilmore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 432 N. Gilmore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ada V Matthews

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Col. | Married |

6 (b) Name of husband or wife James Matthews
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1912

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 34 | 7 | 22 | hr. min. |

9. Birthplace Howard Co. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Richard Johnson
13. Birthplace Howard Co Md.

MOTHER
14. Maiden Name Marie Thorn
15. Birthplace Howard Co Md.

16 (a) Informant Marie Johnson
(b) Address 432 N. Gilmore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 24 1947 (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Catonsville Md.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

FEB 22 1947 (b) Huntington Hall Registrar
(Date received by Registrar)

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb. 20 1947, at 10P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1947 to Feb 20 1947 and that I last saw h[illegible] alive on Feb 20 1947.

| Immediate cause of death | Duration |
|---|---|
| Abscess Lung | 8 days |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23.** Signature B. J. Hafetz M. D.
Address 1 W Pleasant St Date signed Feb 22 1947

G48891 BALTIMORE CITY HEALTH DEPARTMENT G48891

# CERTIFICATE OF DEATH 131a

Registered No.

Every item of information should be carefully supplied. Write PLAINLY, WITH UNFADING INK. Every blank must be filled. Where age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1819 W. Franklin St
(c) Hospital or institution: 4°
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give county)
(d) Street No. 1819 W. Franklin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lillie Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Joseph Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1880

8. AGE: Years 66 | Months 9 | Days 11 | If less than one day: hr. min.

9. Birthplace: Washington D.C.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Thomas Harris
13. Birthplace: Washington D.C.

MOTHER
14. Maiden Name: Anna ?
15. Birthplace: Washington D.C.

16 (a) Informant: Bernice Fikes
(b) Address: 1819 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 23, 1947 (month) (day) (year)
(c) Cemetery or crematory: Arbutus Memorial
Location

18 (a) Funeral director: Mrs Katie R. Williams
(b) Address: 323 N. Schroeder St

19 (a) FEB 23 1947 (Date rec'd by registrar) (b) Baltimore, Md. (Registrar)

S 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb 19 1947 at 10P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 12/14 1946 to 2/19 1947 and that I last saw h[illegible] alive on 2/19 1947.

Immediate cause of death: Hypertensive Cardio Renal Vascular — Duration: 3 yrs

Due to: — Duration: 2 yrs

Due to: — Duration: 8 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. N. Fakehar
Address 17 rd Parker Date signed 2/22/47 D.

X

G48892

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 194a

Registration No. G48892

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5111 York Road
(c) Hospital or institution: 7-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore City,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 528 Beaumont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Leo Farrell

3 (b) If veteran, name war: World War # 1
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Rita Edwards Farrell
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) March 21, 1897
8. AGE: Years 49 | Months 11 | Days 0 | If less than one day ____ hr. ____ min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Railway Mail Service,
11. Industry or business

FATHER
12. Name J. J. Farrell,
13. Birthplace Maryland,

MOTHER
14. Maiden Name Anastatiaca Forestell,
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Rita Farrell,
(b) Address 528 Beaumont Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn,
Location Woodlawn, Md.

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) FEB 22 (Date rec'd by registrar) (b) 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 21 1947, at 10.10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 21 1946 to 2/7 1947 and that I last saw him alive on 2/7 1947

| Immediate cause of death | Duration Sudden |
|---|---|
| Coronary Thrombosis | |
| Due to Coronary Arteriosclerosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Bruce Farrell, M.D.
Address 5839 York Road. Date signed 2/22/47

V S 190

G48893

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13B

G48893 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 604 Jasper Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Jasper Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Norman Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-14-0449

4. Sex: male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1895

8. AGE: Years 51 | Months 11 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation unemployed.

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Margaret Justice
(b) Address 614 Jasper St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 23 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Cal Cemy
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) FEB 23 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 19, 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 5 1946 to Feb 19 1947.
and that I last saw h[illegible] alive on Feb 13 1947.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Tuberculosis | about 2 years |
| Due to | |
| Due to | |
| Other Conditions None | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. Pettet M. D.
Address 817 Hamilton Ave Balto Md Date signed Feb 24 1947

VS 150

X

AB- 107806 C48894

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13B

Registered No. C48894

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 Sharp St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Thomas Joseph McFarland

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30- 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 7 | 21 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Michael McFarland
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Campbell
15. Birthplace Ireland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd

18 (a) Funeral director
(b) Address 1218 Light St

19 (a) (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION** PM

20. DATE OF DEATH Feb. 21 19 47, at 2.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-24 1947, to 2-21 19 47, and that I last saw h im alive on 2-21 19 47

Immediate cause of death Pulmonary Tuberculosis — Duration @ 9 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature
Address Baltimore City Hosp. Date signed Feb 22 1947 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FEB 23 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48895 — BALTIMORE CITY HEALTH DEPARTMENT — G48895 Registered No.

# CERTIFICATE OF DEATH 131a

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: 1763 Homestead Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days):

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 1763 Homestead St.
(If rural give location)
(e) Citizen of foreign country?: (Yes or No)
If yes, name country:

**3 (a) FULL NAME:** MARGARET F. McHale

3 (b) If veteran, name war: ---
3 (c) Social Security Account No.: ---

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Peter McHale
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 1877
8. AGE: Years: 70 | Months: | Days: | If less than one day: hr. min.
9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual Occupation:
11. Industry or business: At Home

FATHER
12. Name: Micheal Roddy
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Margaret F. Roddy
15. Birthplace: Ireland

16 (a) Informant: Mr. Joseph McHale
(b) Address: 1763 Homestead St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2/24/47 (month) (day) (year)
(c) Cemetery or crematory: Cathedral Cem
Location: City

18 (a) Funeral director: WIEDEFELD AND SON
(b) Address: GREENMOUNT AVE & 22ND

1947 FEB 23 (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: 2/20/47, 19..., at 8:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17 1947 to Feb 20 1947 and that I last saw h[e] alive on Feb 19 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary Embolism | 1 hr |
| Mitral Regurgitation | 3 d |
| Due to Arterio Sclerosis | 3 y |
| Hypertension | 2 y |
| Due to Cerebrovascular Accident | 3 d |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?: (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?: (Specify type of place) While at work?:
(e) Means of injury:
23. Signature: I F A Stevens M. D.
Address: 2818 Harford Rd Date signed: 2-21-47

VS 150

G48896 BALTIMORE CITY HEALTH DEPARTMENT G48896

# CERTIFICATE OF DEATH 136

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4605 Kernwood Avenue
(c) Hospital or institution:
77
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4605 Kernwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Julia McGrath Gregory

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: James B. Gregory

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1877

8. AGE: Years: 70 Months: Days: If less than one day hr. min.

9. Birthplace: Ireland (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER
12. Name: John McGrath
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Johanna Murphy
15. Birthplace: Ireland

16 (a) Informant: Mrs Mary Lyng
(b) Address: 4 677 Kernwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/22/47 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: City

18 (a) Funeral director: WIEDEFELD AND SON
(b) Address: Greenmount Ave & 22nd

19 (a) (Date received by registrar) (b) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/19 1947, at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1-1947 to 2-19-1947 and that I last saw her alive on 2-18 1947

Immediate cause of death: Pulmonary Tuberculosis — Duration: 2 yr.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify other place)
(e) Means of injury
23. Signature: [illegible] M.D.
Address 524 York Rd Date signed 2/20/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48897

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V61

Registered No. G48897

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver St
(c) Hospital or institution St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs. ~~mos.~~ days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 331 E 31st St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Catherine 13 McCabe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife late John J McCabe
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1866

8. AGE: Years 80 | Months 6 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John J Kaufmann
13. Birthplace Germany

MOTHER
14. Maiden Name Agnes Schuessler
15. Birthplace Germany

16 (a) Informant James A Brannigan
(b) Address 331 E 31st St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 25/47 (month) (day) (year)

(c) Cemetery or crematory Greenland memorial Park
Location Taylor ave.

18 (a) Funeral director Harry H Wetzke
(b) Address 4101 Edmondson ave

19 (a) FEB 25 1947 (Date rec'd by registrar) (b) Wilson Williams M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 22 1947 at 9.50 AM

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 26 1947 to Feb 22 1947 and that I last saw HER alive on Feb 22 1947

| Immediate cause of death | Duration |
|---|---|
| Cardio respiratory failure | |
| Due to Hypertensive C.V.D. | |
| Due to Diabetes Mellitus | |
| Other Conditions Diabetic gangrene of left foot | |

(Include pregnancy within 3 months of death)

Date of operation Feb 18, 1947

Major findings of operation Gangrene of left foot

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jay F Wilson Jr M. D.
Address St Joseph's Hosp Date signed Feb 27

G48898 BALTIMORE CITY HEALTH DEPARTMENT G48898
Registered No.

# CERTIFICATE OF DEATH 1467

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Saratoga + Calvert
(c) Hospital or institution Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Mercy Hospital (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary E. Haggerty

3 (b) If veteran, name war
3 (c) Social Security Account No:

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18 1862

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 84 | 3 | 2 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Michael Haggerty
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Duggan
15. Birthplace Ireland

16 (a) Informant Sister Mary Xavier
(b) Address 521 Windsor Mill Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 24 '47 (month) (day) (year)
(c) Cemetery or crematory Mount Calvary
Location Old Frederick Rd.

18 (a) Funeral director Henry H. Stifler
(b) Address 4101 Edmondson Ave

19 (a) FEB 25 1947 (Date received by registrar) (b) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 1947 at 8:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 11 1947 to Feb 20 1947 and that I last saw him alive on Feb 19 1947

| Immediate cause of death | Duration |
|---|---|
| Intestinal Obstruction | |
| Due to Probable Ca of Rectum | |
| Due to Generalized Carcinomatosis | |
| Other Conditions Terminal Bronchopneumonia | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clarence E. McWilliams M. D.
Address Mercy Hospital Date signed 2-20-47

Huntington Williams, MD

G48899

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

93c

Registered No. G48899

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Rechester & Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Carroll.
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ivan Elsie Bollinger

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W. | Married |

6 (b) Name of husband or wife Herbert Bollinger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | | | hr. min. |

9. Birthplace BALTO. CITY (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name WM. T. SHIPLEY
13. Birthplace BALTO. CITY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace UNKNOWN

16 (a) Informant WM. E. BOLLINGER
(b) Address HAMPSTEAD ROUTE 1 MD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB. 26 '47 (month) (day) (year)
(c) Cemetery or crematory MEADOW BRANCH
Location CARROLL CO.

18 (a) Funeral director H. BAUMGARDNER & SON
(b) Address WESTMINSTER, MD.

19 (a) (b)

(Signature of registrar)

FEB 24 1947

Registrar

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 2-22-47 19 , at 5:45 P.M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2-17-47 19 to 2-22 1947 and that I last saw her alive on 2-22- 1947

Immediate cause of death Cardiac Failure — Duration
Rheumatic Carditis Vascular Disease
& Cardiac Decompensation Grade
Due to TB
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23.** Signature Charles H. Baumgardner M. D.
Address University Hospital Date signed 2-23-47

Huntington Hospital

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

648900 BALTIMORE CITY HEALTH DEPARTMENT 648900
CERTIFICATE OF DEATH (937) Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4015 Ridgecroft Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4015 Ridgecroft Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Filbert.
3 (b) If veteran, name war
3 (c) Social Security Account No. ✓
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Gertrude Filbert
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 5, 1872
8. AGE: Years 74 Months 11 Days 16 If less than one day hr. min.
9. Birthplace Pa (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business
FATHER 12. Name William Filbert Sr.
13. Birthplace Germany
MOTHER 14. Maiden Name —
15. Birthplace
16 (a) Informant Mrs. Gertrude Filbert
(b) Address 4015 Ridgecroft Road
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/47 (month) (day) (year)
(c) Cemetery or crematory Oaklawn Cemetery
Location Eastern ave
18 (a) Funeral director Howard M. Blight Jr.
(b) Address 4914 Belair Road
19 (a) Harrington Williams (Date rec'd by registrar) FEB 24 1947

MEDICAL CERTIFICATION
20. DATE OF DEATH 2 21 1947, at 5 30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to 2/21 1947 and that I last saw him alive on 2/19 1947
Immediate cause of death
(a) Cardiac Dilatation — Duration 1 Yr.
Due to Ch Myocarditis
Due to Hypertension
Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature J. B. Standing M.D.
Address 4810 Belair Rd Date signed 2/24/47

VS 150

C18901

BALTIMORE CITY HEALTH DEPARTMENT

TM. 107890

# CERTIFICATE OF DEATH

83B

Registered No. C18901

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 S. Charles St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** James Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Married |

6 (b) Name of husband or wife Daisy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16th 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 6 | 23 | hr. min. |

9. Birthplace Ga. (Town, county, and state)
10. Usual Occupation Steel Worker
11. Industry or business

FATHER
12. Name Luke Robinson
13. Birthplace Ga.

MOTHER
14. Maiden Name Martha Ballard
15. Birthplace Ga.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records)

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo FEB 20 1947

18 (a) Funeral director Commissioner of Health
(b) Address
FEB 24 1947 (b)
(Date rec'd by registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9th 1947 19 at 11.40 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 24 1947 to Feb. 9th 1947 and that I last saw h im alive on Feb. 9th 1947

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia | |
| Due to Unknown Cause | |
| Due to | |
| Other Conditions Arteriosclerosis | |
| ② Cerebral thrombosis | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at A.M. P.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin C. Evans M. D.
Address Balto. City Hospitals Date signed Feb 17, 47

107

C18902

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

C18902 Registered No.

CWK-60257 838

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6- 3- 22-
(e) Length of stay in Baltimore (yrs., mos., or days) 86- 2- 9-

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. No home address
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles Rosier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 4-1860

8. AGE: Years 86 | Months 03 | Days 9 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Nelson Rosier
13. Birthplace Maryland

MOTHER
14. Maiden Name Raphael Miccasting
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo FEB 20 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 24 1947 (Date rec'd by registrar) (Signature of registrar)

VS 190

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 13, 1947, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Octo 21 1940 to Febo 13 1947 and that I last saw him alive on Febo 13 1947

| Immediate cause of death | Duration |
|---|---|
| Respiratory Failure | |
| Due to Cerebral Thrombosis | |
| Due to | |
| Other Conditions Generalized arteriosclerosis (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edwin C. Evans, M. D.
Address Balto. City Hospitals Date signed Feb 17, 47

G48903

BALTIMORE CITY HEALTH DEPARTMENT

TM. 108150

# CERTIFICATE OF DEATH

X 1147

Registered No. G48903

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Pulaski Highway & Ebernezer Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Joseph Rosello

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

| 8. AGE: | Years | Months | Days | If less than one day |
|---|---|---|---|---|
| ? | 55 | | | hr. min. |

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records )

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo FEB 20 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 24 1947 (b) [signature]
(Date rec'd by registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 6th 1947 19 , at 12.35 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 3rd 1947 to Feb. 6th 1947 and that I last saw him alive on Feb. 6th 1947.

| Immediate cause of death | Duration |
|---|---|
| [illegible] | ? |
| Due to Cardiac dilatation | ? |
| Due to Multiple Arteriosclerosis | 2 |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Baltimore City Hosp. Date signed 2-6-47

X

G48904 Birth Certificate B-71195

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 157E

Registered No. G48904

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 876 Washington Blvd.
(c) Hospital or institution: Doctors Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1431 Filbert Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Baby Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/18/47

8. AGE: Years | Months | Days | If less than one day hr. 10 min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Edward Murphy
13. Birthplace Uniontown, Pa.

MOTHER
14. Maiden Name June O'Neal
15. Birthplace Uniontown, Pa.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 20 1947

18 (a) Funeral director Commissioner of Health
(b) Address
FEB 24 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** February 18 19 47, at 9:50 A.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death: Congenital Heart — Duration: 10 Mins

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jim R Johnson M.D.
Address 703 Med Arts Date signed 2-18-47

ARCo. 5-41 2500

# HEALTH DEPARTMENT—CITY OF BALTIMORE

G48905 — 194a — G48905

## CERTIFICATE OF DEATH

1. PLACE OF DEATH — Registered No.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2901 Whitney Ave. Ward)

Length of residence in city or town where death occurred.....yrs. 7 mos. ..... How long in U.S. If of foreign birth?.....yrs.....mos.....ds.

2. FULL NAME James E. Ross

(a) Residence: No. 2901 Whitney Ave. Ward.
(Usual place of abode) (If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. Color or Race | 5. Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Male | W. | Married |

3a. If married, widowed, or divorced, HUSBAND of (or) WIFE of Charlotte Ross

6. DATE OF BIRTH (month, day, year) 2/10/1868

| 7. AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 79 | | 14 | |

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Fairfax Va

FATHER
13. NAME John Ross
14. BIRTHPLACE (city or town) (State or country) Fairfax Co. Va.

MOTHER
15. MAIDEN NAME Mary Lee
16. BIRTHPLACE (city or town) (State or country) Va.

17. INFORMANT Frances Jane Courtney Lee
(Address) 2901 Whitney Ave. Balto Md.

18. BURIAL, CREMATION, OR REMOVAL
Place Fairfax Va Date Feb 28th 1947

19. UNDERTAKER J. S. Everly
(Address) Alexandria, Va.

20. FILED FEB 24 1947 Huntington Williamsville, Md.

### MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Feb. 24th, 1947.

22. I HEREBY CERTIFY, That I attended deceased from Dec 6 1946 to Feb 24 1947

I last saw him alive on Feb 24 1947 death is said to have occurred on the date stated above, at 5 A.M.

The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Coronary Thrombosis | |
| | |
| | |
| | |
| | |
| Other contributory causes of importance: | |
| Arteriosclerosis | ? |

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?.....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?..... If so, specify.....

(Signed) Samuel D. Cohen M. D.

(Address) 3711 Pulaski Rd

State CAUSE OF DEATH in plain terms. Do not use abbreviations or ditto marks. State OCCUPATION in every case. See instructions on back of certificate.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48906

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G48906 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 230 N Washington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County B[redacted]
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 230 N Washington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John L Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Margaret L Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 5 1864

8. AGE: Years 82 | Months 6 | Days 16 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Broom Maker

11. Industry or business

FATHER 12. Name Don't Know
13. Birthplace Baltimore

MOTHER 14. Maiden Name Don't Know
15. Birthplace Baltimore

16 (a) Informant Mrs Mary Sullivan
(b) Address 230 N Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 25 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Pleasant St

19 (a) Filed Feb 27 1947 Registrar for Baltimore, Md.
(Date received by registrar)

VS 50

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feby 21 1947, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1947 to Feb 20th 1947 and that I last saw h[redacted] alive on Feb 20th 1947

| Immediate cause of death | Duration |
|---|---|
| Cardio Vascular | |
| Due to Uremia | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H J Jenkins M. D.
Address 100 N Milton Ave Date signed 2/27/47

X

G48907

BC# G69565

JL- 107936

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G48907

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 22 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1632 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy Gillard-Mamie

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 22 | hr. min. |

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Hugh Gillard
13. Birthplace Ga.

MOTHER
14. Maiden Name Mamie Lee Rembert
15. Birthplace S. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) [illegible] cremated (b) Date thereof 2-17-47
(Burial, cremation, or [illegible]) (month) (day) (year)
(c) [illegible] crematory Baltimore City Hospitals
Location 4940 Eastern Ave ( Records )

18 (a) Funeral director
(b) Address

19 FEB 24 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 17 1947, at 1.40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 26 1947, to Feb. 17 1947, and that I last saw h. is alive on Feb. 17 1947.

| Immediate cause of death | Duration |
|---|---|
| (a) Pneumonia | 10 days |
| Due to | |
| Due to | |
| Other Conditions Prematurity | 22 days |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julian P. Mueller M. D.
Address Balt City Hosp Date signed 17 Feb 1947

VS 150

X

G48908 BCH BALTIMORE CITY HEALTH DEPARTMENT G48908

AB- 107937 G69557 CERTIFICATE OF DEATH 119a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1026 S. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Baby Boy Denton

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26-1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | - | 20 | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Denton
13. Birthplace Maryland

MOTHER
14. Maiden Name Rebecca Elliott
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof 2-19-47 (month) (day) (year)
(c) Name of crematory Baltimore City Hospitals
Location 4940 Eastern Ave ( Records )

18 (a) Funeral director
(b) Address

19 (a) FEB 24 1947 (Date filed by city registrar) (b) Huntington Williams M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 16 1947, at 3.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-26- 1947 to 2-16 1947, and that I last saw him alive on 2-16- 1947.

Immediate cause of death: Diarrhea — Duration: 10 days

Due to:

Due to:

Other Conditions Prematurity — 20 days

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julian P. Coffin M. D.
Address Balt City Hosp Date signed 17 Feb 1947

X

G48909 BCH BALTIMORE CITY HEALTH DEPARTMENT G48909

JL - 108343 G70781 CERTIFICATE OF DEATH 122B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 6

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1523 Mullikin Ct. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

**3 (a) FULL NAME** Baby Boy Davenport- Bernice

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb.11, 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 4 | hr. min. |

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James F. Fields, Jr.

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Bernice Davenport

15. Birthplace Md.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Crematory (b) Date thereof 2-17-47 (month) (day) (year)

(c) Name of crematory Baltimore City Hospitals

Location 4940 Eastern Ave ( Records )

18 (a) Funeral director

(b) Address

19 (a) FEB 24 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 15 1947, at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 11, 1947 to Feb. 15 1947 and that I last saw him alive on Feb.15 1947.

| | Duration |
|---|---|
| Immediate cause of death Peritonitis | 1 day |
| Due to Abscess & perforation of sigmoid colon | life |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation Feb. 15, 1947

Major findings of operation: same

of autopsy: same

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wilson E. Hughes M. D.

Address Balto City Hosp Date signed Feb 1947

VS 150

G48910 Baltimore City Dist. No. 208452 S. 71139

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

Registered No. G48910

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13h-10m
(e) Length of stay in Baltimore (yrs., mos., or days) 13h-10m

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Girl Benick- Grace

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | 13 hr. 10 min. |

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Carl
13. Birthplace N. C.

MOTHER
14. Maiden Name Grace Black
15. Birthplace N. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 2-17-47 (month) (day) (year)
(c) Name of cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave ( Records )

18 (a) Funeral director
(b) Address

19 (a) FEB 24 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 15 1947, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 14 1947 to Feb. 15 1947, and that I last saw her alive on Feb. 15 1947.

| Immediate cause of death | Duration |
|---|---|
| Prematurity | Life |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Simon E. Hughes M. D.
Address Balto City Hosp Date signed Feb 19 47

X

File G48911 JL - 108104 BH G 70194

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

159

Registered No. G48911

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 125 S. Gilmore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Girl Berlin- Thelma "B"

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 13 | hr. min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Thelma Berlin
15. Birthplace Md.

16 (a) Informant B. C. Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof 2-17-47
(burial, cremation, removal) (month) (day) (year)
(c) crematory Baltimore City Hosp.
Location 4940 Eastern Ave ( Records )

18 (a) Funeral director
(b) Address

19 (a) FEB 24 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14 1947, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1947, to Feb. 14 1947, and that I last saw h. alive on Feb. 14 1947.

| Immediate cause of death | Duration |
|---|---|
| Aspiration pneumonia | 3 hr |
| Due to Prematurity | life |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy Gaul

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes M.D.
Address Balto City Hosp. Date signed Feb 16 '47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48912

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 B

G48912 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 621 S. Ellwood, Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 621 S. Ellwood, Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** WILLIAM KOMMALAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 2, 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 4 | 19 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Pipe Fitter's Helper
11. Industry or business

FATHER
12. Name Frederick Kommalan
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Margaret Kommalan
(b) Address 621 S Ellwood, Ave.

17 (a) Burial (b) Date thereof 2 25 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Rd.

18 (a) Funeral director Lutz Zeiler, MK.
(b) Address 403 S Wolfe, St.

19 (a) (b)
(Signature of registrar) Registrar

FEB 24 1947

V S 150

Hunting for Williams

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 21 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1946 to Feb 21 1947, and that I last saw him alive on Feb 21 1947.

Immediate cause of death Metastatic Carcinoma of lungs — Duration 7

Due to Carcinoma, Intestinal — Duration since 8/2/46

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Anthony J. Thomas M. D.
Address 4600 York Rd Date signed 4/2/47

X

G18913 CWK-106397 004 G40914

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1107

Registered No. G18913

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Year

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town 641 Portland Street (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore- (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Wayne Schindler

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 10-1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 1 | 0 | 12 | hr. min. |

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Frank Schindler
13. Birthplace Maryland

MOTHER 14. Maiden Name Margaret
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Lilly & Bleiler, Inc.
(b) Address 403 S. Wolfe, St. Balto. Md.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 24 1947

VS 150

## MEDICAL CERTIFICATION

P

20. DATE OF DEATH February 22 19 47, at 2:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 21 19 47 to Feb. 22 19 47, and that I last saw h... alive on Feb. 22 19 47.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Angio's | 1 day |
| Due to Bronchopneumonia | 3 days |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes, M.D.
Address Balto City Hosp Date signed 2-23-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

No. C48914

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 838

Registered No. C48914

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4001 Bellona Ave.
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2915 Oakcrest Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Thomas C. Thatcher

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | widowed |

6 (b) Name of husband or wife Elsie Pearce Thatcher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 30, 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 4 | 22 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Bookkeeper
11. Industry or business

**FATHER**
12. Name Jesse Albert Thatcher
13. Birthplace Baltimore, Md.

**MOTHER**
14. Maiden Name Nannie N. Chasteau
15. Birthplace Baltimore, Md.

16 (a) Informant William P. Thatcher
(b) Address 2915 Oakcrest Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/47 (month) (day) (year)
(c) Cemetery Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1905 Eutaw Place

FEB 24 1947 (b) Huntington Williams, M.D.
(Date received by registrar) (Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 21 1947, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 21 1947 to Feb 21 1947 and that I last saw h[illegible] alive on Feb 21 1947

Immediate cause of death

| | Duration |
|---|---|
| Paralysis | 3 years |
| Due to | |
| Due to | |
| Other Conditions Cerebral Hemorrhage | mos. |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

(PHYSICIAN) Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Richardson
Address 112 W. 25th St. Date signed Feb 24 1947

VS 150

G48915

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G48915

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2814 Maryland Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2814 Maryland Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Emory Burbage

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Mattie Abell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 10 | 16 | hr. min. |

9. Birthplace (Town, county, and state)
10. Usual Occupation Accountant
11. Industry or business Standard Oil Co.

FATHER
12. Name John Emory Burbage
13. Birthplace Kent Co., Md.

MOTHER
14. Maiden Name Annie S. Warner
15. Birthplace Baltimore

16 (a) Informant Mrs. Mattie A. Burbage
(b) Address 2814 Maryland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/47 (month) (day) (year)
(c) Cemetery Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) FEB 24 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 1947, at 3.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1946 to 2/21 1947. and that I last saw h alive on 2/20 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | 24 Hrs |
| Due to Angina | 10 yrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles F. O'Donnell M.D.
Address 7301 York Rd Date signed 2/24/47

VS 190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48916

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 448

Registered No. G48916

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland **Levindale Home**
(b) Street address
(c) Hospital or institution: **Belvedere & Greenspring Ave**
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) **27 Yrs**

**2. USUAL RESIDENCE OF DECEASED:**
(a) State **Md** (b) County
(c) City or town **Baltimore**
(If outside city or town limits, write RURAL and give town)
(d) Street No. **Levendale Home**
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME **SELMA KAPLAN**

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex **F**

5. Color or race **White**

6 (a) Single, married, widowed, or divorced. **Widow**

6 (b) Name of husband or wife **Late Max**

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) **1853**

8. AGE: Years **94** Months Days If less than one day hr. min.

9. Birthplace **Russia**
(Town, county, and state)

10. Usual Occupation
11. Industry or business **None**

FATHER 12. Name **Israel Dubovsky**
13. Birthplace **Russia**

MOTHER 14. Maiden Name **Etta ?**
15. Birthplace **Russia**

16 (a) Informant **Benjamin Kaplan**
(b) Address **1720 N Pulaski St**

17 (a) **Burial** (b) Date thereof **Feb, 24, 1947**
(Burial, cremation, or Removal) (month) (day) (year)
(c) Cemetery or crematory **Bnai Israel Cemetery**
Location **Southern Ave**

18 (a) Funeral director **Sol Levinson & Bros**
(b) Address **1124-1126 W North Ave**

19 (a) **FEB 24 1947** (b) **Huntington Williams, M.D.**
(Date received by Registrar) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH **2-22** 19**47**, at **5**15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from **2-12** 19**47** to **2-22** 19**47** and that I last saw h**e** alive on **2-22** 19**47**.

| Immediate cause of death | Duration |
|---|---|
| **Hodgkin's Disease** | |
| Due to | |
| Due to | |
| Other Conditions **Arteriosclerosis generalized** | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature **Henry Nagel** M. D.
Address **Levindale Home** Date signed **2-22-47**

X

G18917

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131B

Registered No. G18917

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 625 N.Carey St
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 625 N.Carey (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** FLORA EPPS

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex: F
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Robert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/23/1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | 5 | 28 | hr. min. |

9. Birthplace New York (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robt. Free
13. Birthplace New York

MOTHER
14. Maiden Name Margaret Peterson
15. Birthplace New York

16 (a) Informant Robert Epps(H)
(b) Address 625 N.Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25/47 (month) (day) (year)
(c) Cemetery or crematory New Vernon
Location New Vernon, N.Y.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N.Carrollton Ave

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 24 1947

VS 150

Huntington for Williams

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 21st, at 9:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-30- 1947 to 2-21- 1947 and that I last saw h.. alive on 2-21- 1947.

Immediate cause of death C. hepatitis — Duration 2 weeks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. I. Camper M. D.
Address 639 N. Carey Date signed 2-24-47

X

G48918

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 121

G48918 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd & CALVERT STS
(c) Hospital or institution: Union Memorial Hosp'l
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3001 N Calvert (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** ROSE McGOWAN

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| W | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | M |

6 (b) Name of husband or wife WILLIAM McGOWAN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 7 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 76 | 11 | 15 | hr. min. |

9. Birthplace OHIO (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name JOSEPH WHITAKER
13. Birthplace OHIO

MOTHER
14. Maiden Name ROSANA WAGGAMAN
15. Birthplace OHIO

16 (a) Informant MRS GRACE LAZENBY
(b) Address TEMPLE COURT APTS BALT

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/25/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) FEB 24 1947 (Date received by local registrar) (b) Baltimore Md

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 22 1947; at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 21 1947 to Feb 22 1947 and that I last saw h[illegible] alive on 22 Feb 1947

| Immediate cause of death | Duration |
|---|---|
| [illegible] | |
| Due to [illegible] | 1 Hour |
| Due to | |
| Other Conditions Diabetes Acute Appendicitis | ? |

(Include pregnancy within 3 months of death)
Date of operation 21 Feb 1947
Major findings of operation: Acute appendix
of autopsy: [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph C. Presta M. D.
Address Union Mem'l Hosp Date signed Feb 22 1947

VS-150

X

G48919

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G48919 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 No Caroline St.
(c) Hospital or institution: St Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 N. Wolfe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Jane Ironsides

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Widowed |

6 (b) Name of husband or wife: John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25th 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 8 | 27 | hr. min. |

9. Birthplace: Scotland (Town, county, and state)
10. Usual Occupation: Housework
11. Industry or business: Own Home

FATHER
12. Name: James Alexander
13. Birthplace: Scotland

MOTHER
14. Maiden Name: Annie Lewis
15. Birthplace: Scotland

16 (a) Informant: Mrs Charles Naditch
(b) Address: 1702 N. Wolfe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25/47 (month) (day) (year)
(c) Cemetery or crematory: Balto.
Location: Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 190 FEB 24 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 22 1947 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-22- 1947 to 2-22- 1947 and that I last saw h[illegible] alive on 2-22- 1947

| Immediate cause of death | Interval |
|---|---|
| Acute Congestive Cardiac Failure | |
| Due to: Hypertension | |
| Due to: Arteriosclerosis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: [illegible] M. D.
Address: 1 E. Fayette Date signed 2/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48920

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 49a

Registered No. G48920

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1131 NANTICOKE ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1131 NANTICOKE ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GLADYS. M. REED

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-03-0343

4. Sex: FEM.

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 11- 1915

8. AGE: Years 31 | Months 2 | Days 11 | If less than one day hr. min.

9. Birthplace BALTIMORE MD
(Town, county, and state)

10. Usual Occupation BEAUTY PARLOR.

11. Industry or business KRESGES

FATHER
12. Name EDWARD H REED
13. Birthplace BALTIMORE MD

MOTHER
14. Maiden Name MINNIE S- WOLLRING
15. Birthplace GERMANY

16 (a) Informant MARG'T L SCHAFER
(b) Address 1131 NANTICOKE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB-25-47 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK.
Location BALTIMORE MD

18 (a) Funeral director BERNARD E HARLE
(b) Address 131 E WEST ST

19 (a) (b)
Date received FEB 24 1947 Registrar

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 22 1947, at 9:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11- 29- 1946, to FEB. 22, 1947, and that I last saw h[illegible] alive on 2- 21- 1947

| | Duration |
|---|---|
| Immediate cause of death Pneumonia | 9 days |
| Due to Multiple lymphatic sarcomatosis | 30 days |
| Due to Carcinoma of L. ovary | 2 |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation FEB 24, 1946

Major findings of operation: Tumor L. ovary, subacute appendicitis

of autopsy: Not done

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice S Abramson M. D.

Address 3300 N. Charles Ave. Date signed 2/24/47

X

G48921 ✓ G48924

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 97

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13'
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Adler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Wolf

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 82 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name unknown
13. Birthplace Russia

MOTHER 14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Louis Morgan
(b) Address 2117 Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-25-47 (month) (day) (year)
(c) Cemetery or crematory
Location Rebrew Friendship Cem

18 (a) Funeral director Jack Lewis & Co
(b) Address 1439 E Baltimore St

19 (a) (Date received by Registrar) 2-24 1947 Waiting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-24 1947, at 3:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1937 to 2-24 1947 and that I last saw h alive on 2-23 1947.

Immediate cause of death: gangrene of both legs.

Duration: 3 yrs

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Lebtow M. D.
Address 1720 E Lom ST Date signed 2/24/47

VS 150

X

G48922

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G48922

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 23 N. COLLINGTON AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 YRS

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 23 N. COLLINGTON AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY LEVIN

3 (b) If veteran, name war —
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife ANNIE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | | | hr. min. |

9. Birthplace RUSSIA
(Town, county, and state)
10. Usual Occupation FARMER
11. Industry or business

FATHER
12. Name ISAAC
13. Birthplace RUSSIA

MOTHER
14. Maiden Name FANNIE
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (b) Date thereof 2-24-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ~~HERRING RUN~~
Location ~~PLOT P. 2 PRIVATE LANE~~ HEBREW FRIENDSHIP ITEM Co.

18 (a) Funeral director JACK LEWIS INC.
(b) Address 2100 EUTAW PL.

19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 24 1947 Huntington

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2-23-47 19 , at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-25 1946, to Feb-23-1947 and that I last saw him alive on Feb-23 1947.

| Immediate cause of death | Duration |
|---|---|
| Myocardial failure | Past |
| Due to Coronary occlusion | about |
| Due to coronary sclerosis | 2 yrs. |
| Other Conditions none | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herman Steidel M. D.
Address 1112 N. Eutaw Pl. Date signed 2/23/47

X

G48923

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 56E

Registered No. G48923

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address BELVEDERE AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BOLTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. GREENSPRING T BELVEDERE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MORRIS PERLMAN

3 (b) If veteran, name war —
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Chaim
13. Birthplace Russia

MOTHER 14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-47 (month) (day) (year)
(c) Cemetery or crematory NORTH POINT RD
Location North Point Rd

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St

19 (a) FEB 24 1947 (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2-22 1947 at 10:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1941 to 2-22 1947 and that I last saw h[illegible] alive on 2-22 1947

Immediate cause of death Bilateral Bronchopneumonia — Duration

Due to — Duration

Due to — Duration over

Other Conditions Mediastinal Lymphosarcoma
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry W Yet M. D.
Address Levindale Hos Date signed 2-22-47

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

G48924

# CERTIFICATE OF DEATH 1947 G48924

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Raynem Ave & Dukeland St
(c) Hospital or institution: West Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2406 Baker St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3(a) FULL NAME Dr Jacob W Lubchansky

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | married |

6 (b) Name of husband or wife Clara Lubchansky
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name Charley
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Clara Lubchansky
(b) Address 2406 Baker St

17 (a) Burial (b) Date thereof 2-25-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bath Filoh
Location Windsor Mill Road

18 (a) Funeral director Earl Lewis Inc
(b) Address 469 E Balto St

19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 22 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1947 at 1:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 17 Feb 1947 to 23 Feb 1947 and that I last saw him alive on 23 Feb 1947.

Immediate cause of death Lobular pneumonia — Duration 1½ mos

Due to

Due to

Other Conditions Atherosclerotic cardiovascular disease

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation

of autopsy None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Donald J. Gleason M. D.
Address 2834 St Paul St Balto-18 Date signed 2-23-47

X

G48925

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G48925

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 da
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Pikesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4104 Colonial Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Edward C. Weis

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | married |

6 (b) Name of husband or wife Grace Horner Weis
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 23, 1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 10 | 29 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business U. S. Printing & Litho. Co.

FATHER
12. Name Louis T. Weis
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Weippert
15. Birthplace Catonsville, Md.

16 (a) Informant Mrs. Grace Horner Weis
(b) Address 4104 Colonial Rd., Pikesville

17 (a) Burial (b) Date thereof 2/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Registrar
(Date rec'd by registrar)

VS 15t

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/22/ 1947, at 8:35 A.M.

21. I certify that I took charge of the remains described above, held an Insp & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 2-22-47

G18926

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 166

G48926
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Gen'l. Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2840 W. North ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Daisy Mae Ross

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife James A. Ross
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1919

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 28 | 0 | 8 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Walter S. Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Augusta E. Harding
15. Birthplace Md.

16 (a) Informant Mr. James Ross
(b) Address 2840 W. North Ave.

17 (a) Burial (b) Date thereof 2/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) FEB 24 1947 Pennington Williams M.D. Registrar

VS 19T

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/24 1947, at 7:55 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wound of Brain

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2/24/47 at 1 P. M.
(b) Where did injury occur? 2840 W. North ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature Howard J. Mendes M.D.
Medical Examiner.
Date signed 2/22/47

X

G18927

503898

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

93D

Registered No. G18927

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 N. Kean Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lohester Towers.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | married |

6 (b) Name of husband or wife Myrtle A. Towers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 0 | 15 | hr. min. |

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual Occupation Ass't. Station Attendant
11. Industry or business Lord Balto. Oil Co.

FATHER
12. Name George Towers.
13. Birthplace Md (Caroline Co.)

MOTHER
14. Maiden Name Julia Loudon
15. Birthplace Md. (Caroline Co.)

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 2/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cem.
Location Randallstown, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 2/24/47 (b)
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

A

20. DATE OF DEATH Feb. 22 1947, at 3.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3 1946 to Feb. 22 1947 and that I last saw him alive on Feb. 22 1947

| Immediate cause of death Resp. failure | Duration |
|---|---|
| Due to Hard failure | |
| Due to ASHD | |
| Other Conditions Exhaustion by | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton Gusack M. D.
Address JHH Date signed 2-22-47

VS 150

GUSACK X

G48928

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46E

Registered No. G48928

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 819 Hamilton Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-3
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 819 Hamilton Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** MARGUERITE E. JUNKINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Albert B. Junkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | 3 | 18 | hr. min. |

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name Dr. Fred Hammond
13. Birthplace Vermont

MOTHER
14. Maiden Name Ida E. Smallwood
15. Birthplace Balto.

16 (a) Informant Mrs. Brice Quick
(b) Address 1019 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem. Balto., Md.
Location

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

FEB 24 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 22, 1947 at 4:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1946 to Feb 22 1947 and that I last saw h[illegible] alive on Feb. 21 1947.

| Immediate cause of death | Duration |
|---|---|
| Cachexia | - |
| Due to Carcinoma of Sigmoid | 1 yr. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation May 1946
Major findings of operation: Carcinoma of Sigmoid with
of autopsy: metastasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lloyd E. Taylor M. D.
Address 3902 Greenmount Ave Date signed 2/24/47

X

G48929

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G48929 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4211 Nicholas Ave.
(c) Hospital or institution:
26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4211 Nicholas Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** EVA BEYER

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widow |

6 (b) Name of husband or wife William Beyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6, ~~1879~~ 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| (77) 80 | 1 | 16 | hr. min. |

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business -

FATHER
12. Name ? Shuster
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Mrs. Mary Seibold
(b) Address 4211 Nicholas Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 22, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1947 to Feb 22 1947. and that I last saw h[illegible] alive on Feb 21 1947

| Immediate cause of death | Duration |
|---|---|
| Congestive Heart Failure | |
| Due to Arteriosclerosis | |
| Due to C-V-Dis. | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward L. Gladman M. D.
Address 907 Dolphin St. Date signed 2/26/47

VS 120 FEB 24 1947 Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 58E

G48930 ✓ Registered No. G48930

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2528 Mc Cullah St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2528 Mc Cullah St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Daisy E. Green ✓

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Ernest W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1885

8. AGE: Years 61 | Months 5 | Days 23 | If less than one day: hr. min.

9. Birthplace Durham, N.C. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Isaac Berry
13. Birthplace Durham, N.C.

MOTHER
14. Maiden Name Candis ??
15. Birthplace Durham, N.C.

16 (a) Informant Mrs. Candis Stewart
(b) Address 1355 N. Eutaw St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 24, 1947 (month) (day) (year)
(c) Cemetery or crematory Cherbert Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Geo. Young & Stallard
(b) Address 1631 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 24 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 21 1947, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1947 to Feb 21 1947 and that I last saw her alive on Feb 21 1947

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia | 9 |
| Due to | |
| Due to Rheumatic Fever | 9 |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I B Stevenson M.D.

Address 14 Bland Hall Date signed Feb 24 1947

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

C48931 46A C48931

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3117 Weaver Ave,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3117 Weaver Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie H. Ford

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Arthur W. Ford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 8 | 16 | hr. min. |

9. Birthplace Oriole Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Wm. Wallace (Ford) Tyler
13. Birthplace Md.

MOTHER
14. Maiden Name Hester A. Jones
15. Birthplace Md.

16 (a) Informant A. Douglas Ford
(b) Address 3117 Weaver Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 25/47 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto. Md.

18 (a) Funeral director Philip Stewart Sons
(b) Address 2024 Orleans St.

19 (a) FEB 24 1947 (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 22, 1947 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 45 to Feb. 22 19 47 and that I last saw h— alive on — 19 —.

Immediate cause of death: Lymphosarcoma. Retro-peritoneal. — Duration

Due to

Due to

Other conditions Arteriosclerotic. Cardio-Vascular Disease (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. P. Stevens M. D.
Address 3400 Edmondson Ave Date signed 2/24/47

VS 150

Hunterstown, Williamsport

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48932

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

937

Registered No. G48932

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Green & Redwood
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2430 E. Monument St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Dashner

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-14-0216

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Anna Dashner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1900

8. AGE: Years 46 | Months 9 7 | Days 20 10 | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Taxi driver

11. Industry or business

FATHER — 12. Name Wm Dashner
13. Birthplace Baltimore

MOTHER — 14. Maiden Name Elizabeth Armscheutz
15. Birthplace Baltimore

16 (a) Informant Philip Dashner
(b) Address 2013 Jefferson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-26-47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Eutaw St

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

FEB 24 1947

VS 150

Hamilton for Williams

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-23-47 19..., at 4:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-9 1947, to 2-23-1947, and that I last saw h[illegible] alive on 2-23-1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary Occlusion | |
| Due to Arteriosclerotic Cardiovascular disease & cardiac decompensation | |
| Due to Grade III | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Myocardial infarction x-ray

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles H. Hawkins M.D.

Address University Hospital Date signed 2-25-47

X

G48933

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

93a ✓

Registered No. G48933

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 24 S. Decker Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 24 S. Decker Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** CARRIE AMELIA BUCK

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| female | white | widowed |

6 (b) Name of husband or wife John Buck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4. 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 4 | 18 | hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Anton Miller
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Germany

16 (a) Informant Mrs. Lena Eckert
(b) Address 433 N. East Ave.

17 (a) Burial (b) Date thereof Feb. 25. 194
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory 1st Evangelical
Location Baltimore Md.
18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address Baltimore Md.
19 (a) (b)
(Date rec'd by registrar) Registrar

VS 130 FEB 24 1947 Huntington Station, Md

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22. 1947 at 2.15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Decemb. 1946, to Feb. 22 1947, and that I last saw her alive on Feb. 22 1947

Immediate cause of death: Acute Myocarditis — Duration: Several days

Due to: Asthmatic Bronchitis — Duration: one year

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy: none

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. A. Rosenblatt M. D.
Address 508 O'Donnell St. Date signed 2-23-47

X

G48934

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

61

Registered No. G48934

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Road
(c) Hospital or institution: Snyder Nursing Home 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3346 Kenyon Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** CUNIGUNDA MATTERN

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife August Mattern

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1874

8. AGE: Years 73 | Months 0 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Burkhardt
13. Birthplace Maryland

MOTHER
14. Maiden Name
15. Birthplace Maryland

16 (a) Informant Mr. Paul A. Mattern
(b) Address 3346 Kenyon Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/ /47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b) Registrar

VS 139 FEB 24 1947

**MEDICAL CERTIFICATION** AM

20. DATE OF DEATH February 21, 1947, at 3.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1947, to Feb 21 1947, and that I last saw h[illegible] alive on Feb 20 1947.

| Immediate cause of death | Duration |
|---|---|
| Nephritis | 6 Mos. |
| Due to | |
| Due to | |
| Other Conditions: Diabetes | 2 yrs. |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jacob Fuchs M. D.
Address 1823 N Wolfe St Date signed Feb 25 47

1316

G48935

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G48935

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 416 E. Chase Street
(c) Hospital or institution:
10
(d) Length of stay in hospital or inst. (yrs., mos., or days) ------
(e) Length of stay in Baltimore (yrs., mos., or days) About 75 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 416 E. Chase Street
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

**3 (a) FULL NAME** Katherine B. Sullivan

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife John F. Sullivan
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ----------

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| About 75 | -- | --- | -- hr. --- min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business -------

FATHER
12. Name John M. Bouchet
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Elizabeth Browne
15. Birthplace Baltimore, Maryland

16 (a) Informant Charles J. Bouchet
(b) Address 206 E. Biddle Street

17 (a) Burial (b) Date thereof 2/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

FEB 24 1947 (b) [illegible] Williams M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 22nd 1947, at 6a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1946 to Feb 22 1947, and that I last saw [illegible] alive on Feb 20 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | days |
| Hypertension | years |
| Due to Chronic Nephritis | years |
| Due to Cardiac Decompensation | |
| Other Conditions Tbc | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Tbc

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [signature]
Address 206 E. Calvert St Date signed Feb 24/47 M. D.

VS 150

X

G18936

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 49a

G48936 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St
(c) Hospital or institution: Union Memorial hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 8
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3706 North Charles St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs. H. Bowers Eleanor G. Dunning Jr. (Eleanor)

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Fem. | White | Married. |

6 (b) Name of husband or wife Mr. H. A. P. Dunning
6 (c) If alive, give age Years

7. Birth date of deceased (mo., day, yr.) May 3 1913

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 33 | 9 | 19 | hr. min. |

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Edward H. Beck.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Virginia Bantz
15. Birthplace Baltimore Md.

16 (a) Informant HOSPITAL RECORDS
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Mrs. W. Mears and Son
(b) Address 905 N. Calvert St.

19 FEB 24 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2-22- 1947 at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 14 1946 to Feb 22 1947 and that I last saw h[illegible] alive on Feb 22 1947.

Immediate cause of death: Papillary Cystadeno-Carcinoma of ovaries — Duration

Due to With Generalized Metastasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Emma B. Chambers M. D.
Address Union Mem. Hosp. 33rd Calvert St. Date signed 2-22- 47

G48937

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G48937 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Da A
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2643 Maryland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Edward V. Mahoney

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| World War I | ✓ |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 58 | 9 | 19 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name William D. Mahoney
13. Birthplace Ireland

MOTHER
14. Maiden Name Matilda Cook
15. Birthplace Baltimore, Md

16 (a) Informant Louis Mahoney
(b) Address 2201 N. Calvert St.

17 (a) Burial (b) Date thereof Feb. 24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director J. A. Kranz & Son
(b) Address 1216 E. Charles St

FEB 24 1947 (b)
(Date rec'd by Registrar) Registrar

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2-21-47 at 4:07 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions Emphysema & Asthma.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Weaver M.D.
Medical Examiner.
Date signed 2-21-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48938 BCH G 34410

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 157a

G48938 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 313 N. Eutaw Place
(c) Hospital or institution: 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 N. Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LINDA LEE LAMBERT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/14/45

8. AGE: Years 1 | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Woodrow Lambert
13. Birthplace Wheelersburg, Ohio

MOTHER
14. Maiden Name Ida Rigsby
15. Birthplace Wheelersburg, Ohio

16 (a) Informant Woodrow Lambert
(b) Address 313 N. Eutaw Place

17 (a) Removal (b) Date thereof 2-24-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Wheelersburg
Location Wheelersburg Ohio

18 (a) Funeral director Wm. Cochenour
(b) Address 1217 St Paul St.

19 (a) 1947 (b) Huntington Williams Mfg Co
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23, 1947, at 12:15 M

21. I certify that I took charge of the remains described above, held an Inquiry Inspection & thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hydrocephalus

Due to Meningitis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G. Pelfrey M.D.
Medical Examiner.
Date signed Feb 24-1947

VS 191

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48939

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓81a

G48939 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: (accident Provident Hospital)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 306 N. Fremont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maxwell E. Riley 2/27/47

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1926

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 20 | 7 | 24 | hr. min. |

9. Birthplace Bayside Accomac Co, Va (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward Riley
13. Birthplace Accomac Co Va

MOTHER
14. Maiden Name Madline Rayfield
15. Birthplace Accomac Co Va

16 (a) Informant Madline Riley
(b) Address 306 N Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 24, 1947 (month) (day) (year)
(c) Cemetery or crematory Facley Va,
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) (Signature by registrar) (b) Mrs Katie R Williams

2-24-1947
VS 150

**MEDICAL CERTIFICATION** 40

20. DATE OF DEATH 2/24 1947, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/21 1947 to 19, and that I last saw h alive on 19.

Immediate cause of death: Cerebrospinal Meningitis (unknown origin) — Duration: Hrs

Due to
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy None

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Adel Corse M. D.
Address 1129 Harlem Ave Date signed 2/27/47

For S. C. J. Zubowski, by Howard J. Mercer, M.D. X

G18940

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

836

G18940 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2558 Wilkens avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County --
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2558 Wilkens avenue (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH FRANCES SHERIDAN

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife James H. Sheridan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 7 | 29 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Daniel Webster Wells
13. Birthplace Anne Arundel Co., Md.

MOTHER
14. Maiden Name Mary Catherine Shields
15. Birthplace England

16 (a) Informant Mrs. Katherine K. Arthur
(b) Address 2558 Wilkens avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Leo J. Evans & Son Inc.
(b) Address 11 N. W. Mt. Royal Ave.

19 (a) FEB 24 1947 (Registered by Registrar) (b) Huntington, W. Va.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 21 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1947 to Feb. 21 1947 and that I last saw h[illegible] alive on Feb. 21 1947

| Immediate cause of death | Duration |
|---|---|
| CEREBRAL EMBOLI | |
| 5 Days | |
| Due to | |
| Due to | |
| Other Conditions Hypertension | |
| 2 yrs. (Include pregnancy within 3 months of death) | |

Date of operation None
Major findings of operation
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide? None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B V Kelly M.D. M. D.
Address 21 N. Linwood Ave. Date signed Feb 27 1947

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

File G48941

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 557

Registered No. G48941

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address U. S. Marine Hospital
(c) Hospital or institution: Balto., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 175 d
(e) Length of stay in Baltimore (yrs., mos., or days) 28 years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3012 Rosalie Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** RAYMOND FRANKLIN BABCOCK

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| WW I | not given |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | married |

6 (b) Name of husband or wife Elizabeth Agnes Babcock 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | 4 | 5 | hr. min. |

9. Birthplace New Bedford, Mass. (Town, county, and state)
10. Usual Occupation machinist
11. Industry or business

FATHER
12. Name Elisha Babcock
13. Birthplace Massachusetts

MOTHER
14. Maiden Name Jennie C. King
15. Birthplace Mass.

16 (a) Informant Records
(b) Address U. S. Marine Hospital

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/26/47 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE NATIONAL
Location FREDERICK ROAD

18 (a) Funeral director Chas. L. Evans & Son
(b) Address 118 W. Mt. Royal Ave

19 (a) FEB 24 1947 (b) Registrar Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 23, 1947 19 , at 7:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 6, 19 46 to Feb. 23, 19 47, and that I last saw him alive on Feb. 23, 19 47.

| | Duration |
|---|---|
| Immediate cause of death Hemmorage from erosion left common carotid artery | 12 days |
| Due to carcinoma of the left pyriform sinus | 1½ yrs. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy as above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Willys R. Monroe Willys R. Monroe M. D.
Address U. S. Marine Hosp. Date signed 2/23/47

VS 150

G18912

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

Registered No. G18912

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun St
(c) Hospital or institution: Franklin Square Hospital D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 Hollins Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** REINHOLD FROEHLICH FROEHLICH

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | widower |

6 (b) Name of husband or wife Fannie Froehlich

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12-1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 2 | 9 | hr. min. |

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation R.R. Brakeman

11. Industry or business

FATHER 12. Name Gustav Froehlich

13. Birthplace Switzerland

MOTHER 14. Maiden Name Anna Fuchs

15. Birthplace Switzerland

16 (a) Informant Mrs. Rose Wachter

(b) Address 1215 Hollins St

17 (a) Burial (b) Date thereof 2/25/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Western Cem

Location Balto Md

18 (a) Funeral director Geo L. Bayer Jr

(b) Address 1512 Hollins St

19 (a) FEB 24 1947 (b) Lexington Williams M.D.
Registrar

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH FEB. (Dec) 21, 1947, at 8.15 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Andersen M.D.
Medical Examiner.

Date signed 2-21-47

X

G48943

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 63a

G48943

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 N. Bond Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** LESSIE JENNINGS

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored. | Married |

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 23, 1909

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 37 | 5 | 29 | hr. min. |

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Spencer Adams
13. Birthplace N. C.

MOTHER
14. Maiden Name Anna Lawson
15. Birthplace N. C.

16 (a) Informant John Jennings
(b) Address 1712 N Dallas St

17 (a) Burial (b) Date thereof Feb. 24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mrs. Robert A. Elliott & Dyer
(b) Address 1129 N. Caroline St

19 (a) FEB 21 1947 Registered by registrar Evelyn Williams, M.D. Registrar

VS 181

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb. 21, 1947 at 10 p M

**21.** I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage, spastic (quadriplegia)

Due to

Other Conditions
(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 2-21-47

X

C18914

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. C18914

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2544 Boyd St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Fullerton
(If outside city or town limits, write RURAL and give town)
(d) Street No. Necker Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emilie A. Vollmert

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widow |

6 (b) Name of husband or wife Berthold Vollmert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3rd, 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 1 | 20 | hr. min. |

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Louis Dorr
13. Birthplace Germany

MOTHER
14. Maiden Name Schrader
15. Birthplace Germany

16 (a) Informant Mrs. Minnie Crais
(b) Address 2544 Boyd St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Feb. 26th, 19 47 (month) (day) (year)
(c) Cemetery or crematory St. Michaels Luth.
Location Fullerton, Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Road

19 (a) (Date received by registrar) FEB 24 1947 (b) Huntington Williams, M.D.

VS 15-

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23rd 19 47 at 11:45 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 20 19 47 to Feb. 23 19 47 and that I last saw her alive on Feb. 22 19 47

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 4 days |
| Due to Arteriosclerosis | Many years |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence At M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Wilkinson, M. D.
Address 5713 Belair Rd. Date signed 2-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48945

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48945 Registered No. 170c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 237 West Preston Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 237 West Preston Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** JOHN WHITE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 15, 1894

8. AGE: Years 52 | Months 3 | Days 7 | If less than one day: hr. min.

9. Birthplace: North Carolina
(City, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: John Westley White
13. Birthplace: North Carolina

MOTHER
14. Maiden Name: Elizabeth Knight
15. Birthplace: North Carolina

16 (a) Informant: Tempey Johnson
(b) Address: 337- W. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-47 (month) (day) (year)

(c) Cemetery or crematory: Mt. Calvary
Location: Cedar Hill Md.

18 (a) Funeral director: Adolphus Halsted
(b) Address: 918 Edmondson Ave. Huntington Station, Md.

19 (a) 1947 (Date rec'd by registrar) (b) Registrar

VS 151

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** February 22, 1947, at 3:30 P.M.

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death, in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

**IMMEDIATE CAUSE OF DEATH** Pulmonary embolism

Hypertrophy and dilatation of heart

Coronary disease, edema and congestion of lung, generalized arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury 11-28-1946 At 5:40 P. Ave. M. 6/3
(b) Where did injury occur? Patterson Park & Jefferson St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work?
(d) Means of injury Struck by auto. (Ped.)

**23.** Signature Howard J. Karlson M.D.
Medical Examiner.
Date signed 2-24-47

G48946 604 G63797

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G48946 Registered No. 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1231 Myrtle Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CAROL STRADFORD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race colored

6 (a) Single, married, widowed, or divorced. child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/29/46

8. AGE: Years | Months 2 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name Ben Stradford
13. Birthplace Langston, S.C.

MOTHER
14. Maiden Name Emogene Floyd
15. Birthplace ?

16 (a) Informant Ben Stradford
(b) Address 534 N. Biddle Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-24-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director Joshua Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24, 1947, at 2 p. M

21. I certify that I took charge of the remains described above, held an insp.& inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia
Upper respiratory infection

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wilcox M.D.
Medical Examiner.
Date signed 2-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48947

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1/31a

G48947 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 Brewer Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** WILLIAM BROWN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | | | hr. min. |

9. Birthplace Raleigh North Carolina (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace North Carolina

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Ruth Anderson
(b) Address 511 W. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-26-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 718 Druid Hill Ave.

19 (a) 1947 (Date rec'd by registrar) (b) [illegible] Registrar

VS 191

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-24 1947, at 1:15 P M

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cardiovascular renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Weaver M.D. Medical Examiner.
Date signed 2-24-47

G48918 BCH B 70197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G48918 Registered No. 747

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1421 Hooker Court.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) 16 days.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1421 Beinder Court.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Thomas Lavato Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | S |

6 (b) Name of husband or wife ~

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/6/47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 0 | 0 | 16 | - hr. - min. |

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation -
11. Industry or business

FATHER
12. Name Andrew Brown
13. Birthplace Winnsboro S.C.

MOTHER
14. Maiden Name Lulu M. Holmes
15. Birthplace Winnsboro S.C.

16 (a) Informant Andrew Brown
(b) Address 1421 Hooker Court.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo FEB 24 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 24 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb. 22 1947, at 9:15 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2-20 1947, to 2-22 1947 and that I last saw h/m alive on 2-20 1947

| Immediate cause of death | Duration |
|---|---|
| Unknown | |
| Due to Prematurity | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23.** Signature R B Lightner M. D.
Address 501 Cherry Hill Rd. Date signed 2-22-47

VS 150

X

G48949

BALTIMORE CITY HEALTH DEPARTMENT ✓ G48949 Registered No.

# CERTIFICATE OF DEATH 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 732 N. Gay Street. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

**3 (a) FULL NAME** CORNELIUS SMITH ✓

3 (b) If veteran, name war: World War I.
3 (c) Social Security Account No. 217-01-9160
4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) 1892
8. AGE: Years 55 54 | Months | Days | If less than one day ..... hr. ..... min.
9. Birthplace Farboro, North Carolina (Town, county, and state)
10. Usual Occupation unemployed
11. Industry or business

FATHER
12. Name Lee Smith
13. Birthplace Farboro- North Carolina

MOTHER
14. Maiden Name Betsy Smith
15. Birthplace Farboro north carolina

16 (a) Informant Rochwell Smith
(b) Address 208- W. 128th St. N.Y.C.
17 (a) Burial (b) Date thereof 2/27/47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Maryland
18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave
19 (a) 2 1947 (Date received by registrar) (b) Lexington Hilliard

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 14, 1947, at 12.30 P M

21. I certify that I took charge of the remains described above, held an Partial autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Lobar Pneumonia

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 2-14-47

VS 181

X

G48950 G48950

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route #40 St Johnsbara
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Boswell

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Judson Boswell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1868

8. AGE: Years 78 | Months 7 | Days 10 | If less than one day hr. min.

9. Birthplace Dchester Balto Co Md
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Anthony Hepdinty
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Hadder
15. Birthplace Germany

16 (a) Informant Mr. Judson Boswell
(b) Address Ellicott City, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 25 47 (month) (day) (year)

(c) Cemetery or crematory Good Shepherd
Location Ellicott City, Md

18 (a) Funeral director Easton Sons
(b) Address Ellicott City, Md

19 (a) FEB 24 1947 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/22 1947, at 730 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/21 1947, to 2/22 1947 and that I last saw h.e alive on 2/22 1947

Immediate cause of death
Ruptured myocardium
Due to Coronary occlusion
Due to
Other Conditions Arterosclerosis

| Duration |
|---|
| |
| |
| |
| |
| |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy Ruptured myocardium

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external cause, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry M. Hodges M. D.
Address St. Agnes Hospital Date signed 2-22-47

G48951

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G48951 Registered No.

# CERTIFICATE OF DEATH 55B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address REDWOOD & GREENE STS
(c) Hospital or institution: UNIVERSITY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Washington
(c) City or town Hagerstown Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Daniel GLENN HULL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dorthy Hull

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1920

8. AGE: Years 26 | Months 4 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace: Clearspring, Md. (Town, county, and state)

10. Usual Occupation: Truck Driver

11. Industry or business: Cushman & Sons

FATHER
12. Name: Paul E. Hull
13. Birthplace: Clearspring, Md.

MOTHER
14. Maiden Name: Alice Clark
15. Birthplace: Clearspring, Md.

16 (a) Informant: Mrs. Dorthy Hull
(b) Address: Williamsport, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/47 (month) (day) (year)
(c) Cemetery or crematory St. Pauls Cem.
Location St. Pauls, Hagerstown Md

18 (a) Funeral director F.K. Leffman
(b) Address Hagerstown Md.

19 (a) ... (Date rec'd by registrar) ... Registrar

FEB 25 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH 24 FEB 1947 at 2:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 26 NOV 1946 to 24 FEB 1947, and that I last saw him alive on 23 FEB 1947

Immediate cause of death: ANAPLASTIC CARCINOMA LEFT HIP & SECONDARY
Due to: INFECTION
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

| | Duration |
|---|---|
| | |
| | |
| | |
| | |
| | |

Date of operation 1-21-47 & 2-12-47
Major findings of operation: 1-21-47 - 1100 - RETROPERITONEAL ABCESS ; 2-12-47 - METAS. LAP - ANAPLASTIC CARCINOMA
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E Bauer M. D.
Address Univ. Hospital Date signed 24 FEB 47

(OVER)

G48952

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. G18952

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 532 N. Gay St
(c) Hospital or institution: 5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 552 N. Gay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Thomas Gavin

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | No. |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W. | W |

6 (b) Name of husband or wife Ada,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9. 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 2 | 13 | hr. min. |

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation Retired Fireman
11. Industry or business Balto City

FATHER
12. Name Mathew Gavin
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Burk
15. Birthplace Ireland.

16 (a) Informant Ada Gavin (Wife)
(b) Address 552 N. Gay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location C. A. Co.

18 (a) Funeral director Wm Godfrey
(b) Address 1217 St Paul St

19 FEB 25 1947 (Date rec'd by registrar) (By) Huntington Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22 1947, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 2, 1946 to Feb 22 1947; and that I last saw him alive on Feb. 22, 1947.

| Immediate cause of death | Duration |
|---|---|
| Uraemia | 4 years. |
| Chronic Nephritis | |
| Due to Arteriosclerosis. | |
| Due to | |
| Other Conditions Generalized Arterio-sclerosis | |

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ~
(b) Date of occurrence ~ at ~ M
(c) Where did injury occur? ~
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ~ While at work? ~
(Specify type of place)
(e) Means of injury

23. Signature Frank M. Ogden M. D.
Address 2701 N. Calvert St. Date signed Feb. 24, 47

VS 150

G48953

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93E

G48953 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3504 Fleet St.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3504 Fleet St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Louise Julia Braun

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | S |

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 29 Dec. 1903

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 43 | 1 | 23 | hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Sales lady
11. Industry or business

FATHER
12. Name Ferdinand Braun
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Hoffman
15. Birthplace Germany

16 (a) Informant Daughter
(b) Address 3504 Fleet St.

17 (a) Burial (b) Date thereof 2/26/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) FEB 25 1947 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Feb 1947, at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 18 Feb 1947, to 22 Feb 1947, and that I last saw h and alive on 21 Feb 1947.

| Immediate cause of death | Duration |
|---|---|
| Acute Respiratory Failure | |
| Due to Arrgestive Heart Failure | |
| Due to Bronchial Pneumonia | |
| Other Conditions None | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles P. Carey M. D.
Address 2722 E. Monument St. Date signed 2-26-47

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48954

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. G48954

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4830 Pimlico Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4830 Pimlico Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** NELLIE A. FRANZ

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Frederick C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1873

8. AGE: Years 73 | Months 8 | Days 26 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: W. Dawson Whitaker
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mary E. Gill
15. Birthplace: Md.

16 (a) Informant: Mrs. Charles D. Franz
(b) Address: 4830 Pimlico Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 26, 1947 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: Baltimore, Maryland

18 (a) Funeral director: William Cook, Inc.
(b) Address: 1217 St. Paul Street

19 FEB 25 1947 (Date rec'd by Registrar) Washington Williamson

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1942 to Feb 26 1947 and that I last saw h.e alive on Feb 22 1947.

| | Duration |
|---|---|
| Immediate cause of death: Cerebral Hemorrhage | |
| Paralysis RT side | |
| Due to: Hypertension | |
| Due to: Generalized Arteriosclerosis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos J. Ward M. D.
Address 4509 Liberty Heights Date signed 2-27

VS 150

G48955 Birth Certificate G-12903

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1600

Registered No. G48955

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1931 Herbert Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1931 Herbert Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Patticord

3 (b) If veteran, name war —

3 (c) Social Security Account No. NINE

| 4. Sex | 5. Color or race | 6 (a) Single, ~~married, widowed, or divorced~~ |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 13th 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 10 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Peddicord
13. Birthplace Ellicott City Md.

MOTHER
14. Maiden Name Irene Johnson
15. Birthplace Balto. Md.

16 (a) Informant Ada Johnson
(b) Address 1931 Herbert St.

17 (a) Burial (b) Date thereof 2/25/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Meadow Branch
Location Carroll Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) FEB 25 1947 (b) Huntington Williams Hillsdale
(Date rec'd by registrar)

VS 151

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** February 23 19 47 at 6 ~~P.~~ A.M.

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Malnutrition & dehydration

Subarachnoid hemorrhage at base

Due to

Other Conditions

(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

**23. Signature** Howard J. Madden M.D.
Medical Examiner.
Date signed 2-24-47

~~618956~~ ~~1838 WESTPHALT PLACE~~

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 929

Registered No. 618956

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. To correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1838 WESTPHALT PLACE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Y
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1838 WESTPHALT PLACE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** MARY F GERMERSHAUSEN

3 (b) If veteran, name war —

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| FEM | WHITE | MARRIED |

6 (b) Name of husband or wife PHILIP GERMERSHAUSEN

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) MAY 1st 1898

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 48 | 9 | 22 | hr. min. |

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business —

FATHER 12. Name EDWARD Mc NEAL

FATHER 13. Birthplace BALTIMORE MD

MOTHER 14. Maiden Name ?

MOTHER 15. Birthplace BALTIMORE MD

16 (a) Informant PHILIP GERMERSHAUSEN

(b) Address 1838 WESTPHALT PLACE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB-26-47 (month) (day) (year)

(c) Cemetery or crematory HOLY CROSS

Location A.A. Co.

18 (a) Funeral director Bernard E Hurle

(b) Address 121 E West St.

19 (a) FEB 25 1947 (Date received by local registrar) (b) Huntington Willi Registrar

VS 130

**MEDICAL CERTIFICATION**

20. DATE OF DEATH FEB. 23 1947 at 1055 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to Feb 23 1947 and that I last saw h[illegible] alive on Feb 23 1947

Immediate cause of death: (a) Bronchial Asthma — Duration 6 mos

Due to: (b) Bronchial Asthma — 1 yr

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy: None

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.

Address 1279 William St Date signed 2/23/47

X

G48957

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G48957 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 617 E 29th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 E. 29th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Harry Stow

3 (b) If veteran, name war

3 (c) Social Security Account No. 716-06-2592

4. Sex: M

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Etta M. Stow

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Feb 3 - 1892

8. AGE: Years 55 | Months — | Days 20 | If less than one day hr. min.

9. Birthplace Camden - Camden N. J.
(Town, county, and state)

10. Usual Occupation Lineman

11. Industry or business Pennsylvania R.R.

FATHER
12. Name John W. Stow
13. Birthplace N.J.

MOTHER
14. Maiden Name Mary C. Mc=Knight
15. Birthplace N.J.

16 (a) Informant Harry Stow Jr.
(b) Address [illegible]

17 (a) removal (Burial, cremation, or removal) (b) Date thereof 2/27/47 (month) (day) (year)

(c) Cemetery or crematory Mem. Pk. Bethel Cem
Location Camden N.J.

18 (a) Funeral director Joseph Farace Jr.
(b) Address 2013 Government Ave

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 25 1947 Huntington Mill

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1947, 3:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1940, to Feb 23 1947, and that I last saw him alive on Feb 23 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary occlusion | |
| Due to | |
| Due to | |
| Other Conditions Diabetes. | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jack J. Singer

Address 50 E North Ave Date signed 2-24-47 M.D.

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. A. Eisenberg G48955

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G48958

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1712 N. Port Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 North Port Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Joseph Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | widowed |

6 (b) Name of husband or wife Mary E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 5 | 24 | hr. min. |

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name Christian Young
13. Birthplace Germany

MOTHER
14. Maiden Name Mary E.
15. Birthplace Germany

16 (a) Informant Miss Agnes Young
(b) Address 1712 North Port Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Registrar

VS 100 FEB 25 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22, 1947 at 9:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from February 18 1947 to February 22 1947 and that I last saw h[illegible] alive on [illegible] 21 1947.

Immediate cause of death: Acute Purulent and Cardiac Dilatation — Duration 4 Days

Due to: Myocardial Insufficiency and General Arteriosclerosis — Duration 3 years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Eisenberg M.D.

Address 2015 E. North Ave. Date signed 2/25/47

X

Dr. C48959

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1316

Registered No. C48959

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Road
(c) Hospital or institution: Snyder's Convelscant Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3105 Louise Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary V. Clayton

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widowed |

6 (b) Name of husband or wife Wells O. Clayton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 7 | 16 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name William C. White
13. Birthplace ?

MOTHER
14. Maiden Name Anna ?
15. Birthplace ?

16 (a) Informant Mrs. Della Clayton
(b) Address 6409 Harford Road

17 (a) Burial (b) Date thereof 2/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Jerusalem Cem
Location Baltimore Harford Co. Md

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 25 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 23rd, 1947 at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 21 1947 to Feb 23 1947 and that I last saw h[illegible] alive Feb 23 1947

| Immediate cause of death | Duration |
|---|---|
| Chronic Myocarditis | 2 years |
| Due to | |
| Due to | |
| Other Conditions Chronic Pancreatitis — Uterine Hysterectomy (Include pregnancy within 3 months of death) | 3 years |

Date of operation none
Major findings of operation:
of autopsy: no

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? none
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury none

23. Signature L. L. Goudy M.D.
M. D.
Address 5106 Harford Rd Date signed 2/24/47

vs 193

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1248

Registered No. C48960

C48960

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2131 Walbrook Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2131 Walbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MABEL L. TITTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Harry R. Titter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 0 | 12 | hr. min. |

9. Birthplace Chesapeake City, Md.
(Town, county, and state)
10. Usual Occupation –
11. Industry or business

FATHER
12. Name James Wharton
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Borem
15. Birthplace Md.

16 (a) Informant Mr. Harry R. Titter
(b) Address 2131 Walbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25/47 (month) (day) (year)
(c) Cemetery or crematory Bethel Cem.
Location Cecil Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntingtown, Md.

FEB 25 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22, 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10- 1946 to 2/22 1947 and that I last saw h alive on 19

| Immediate cause of death | Duration |
|---|---|
| Edema of Lungs | 2 days |
| Due to General Edema | 6 mos. |
| Due to Cirrhosis of Liver | 2 yrs. |
| Other Conditions – | |

(Include pregnancy within 3 months of death)

Date of operation –
Major findings of operation: –
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide –
(b) Date of occurrence – at M
(c) Where did injury occur? –
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? – While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. Pirk, M. D.
Address 2202 W. Fort Ave. Date signed 2-24-47

X

BCH

# BALTIMORE CITY HEALTH DEPARTMENT

G18961 G4236 **CERTIFICATE OF DEATH** 108 ✓ File No. G18961

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 118 - N. Biddle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11'
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 118 - N. Biddle St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** (Baby) Cleo Davis ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | colored | Child |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 11 | 20 24 | hr. min. |

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Ervin Davis
13. Birthplace South Carolina

MOTHER
14. Maiden Name Emmaline Layton
15. Birthplace South Carolina

16 (a) Informant Ervin Davis
(b) Address 118 - N. Biddle St.

17 (a) Burial (b) Date thereof 2/25/47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director G. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 25 1947 Huntington Hillsdale, Md

**MEDICAL CERTIFICATION** 15

**20. DATE OF DEATH** February 24 1947, at 6 P.M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1947 to Feb 20 1947, and that I last saw h~ alive on Feb 20 1947.

| Immediate cause of death | Duration |
|---|---|
| (a) Lobar Pneumonia | 5 da. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23.** Signature James A. McLeod M.D.
Address 2029 Guilford Ave. Date signed Feb 24 1947

X

C48962 JL-107794

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13B

Registered No. C48962

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 53 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1144 Ridgley St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

**3 (a) FULL NAME** Zeta Kohlhoff

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Widowed |

6 (b) Name of husband or wife Richard F. Kohlhoff
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Oct. 5 ?1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 ### ? | ?4 | 28 ## | ##### min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Martin ##### Maher
13. Birthplace Md.

MOTHER
14. Maiden Name Katherine ##### Deer
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Rd.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 FEB 25 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

## MEDICAL CERTIFICATION A

20. DATE OF DEATH Feb. 23, 1947, at 8.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 21 1947, to Feb. 23 1947, and that I last saw her alive on Feb. 23 1947.

Immediate cause of death Pulmonary tuberculosis — Duration 3 mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. F. Schaefer M. D.
Address Baltimore City Hosp. Date signed 2-25-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

C48963

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13B

Registered No. C48963

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 921 Granby Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Paul A. Christoph

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 27, 1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 47 | 10 | 26 | hr. min. |

9. Birthplace St. Charles, Mo. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Oil Tanker

FATHER
12. Name Gotthilf Christoph
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Mackalinski
15. Birthplace Germany

16 (a) Informant
(b) Address

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 2-26-47 (month) (day) (year)
(c) Cemetery or crematory ST. PAUL
Location ST. PAUL, MINN.

18 (a) Funeral director WILLIAM COOK, INC
(b) Address 1217 ST. PAUL ST.

19 (a) FEB 25 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 22, 1947 at 9:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic pulmonary tuberculosis with cavity formation - - bilateral

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mellers M.D. Medical Examiner.
Date signed 2-24-47

(OVER)

G48964

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

119a

Registered No. G48964

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:** Baltimore
(a) State MD (b) County Howard of Co
(c) City or town Woodstock Md (If outside city or town limits, write RURAL and give town)
(d) Street No. DAVIS AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** DOROTHY E. MILLER.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| FEMALE | WHITE | |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-13-48

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 1 | 5 | 4 | hr. min. |

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ELMER J MILLER
13. Birthplace MARYLAND (Baltimore)

MOTHER
14. Maiden Name DOROTHY E (MILLER)
15. Birthplace MARYLAND

16 (a) Informant DOROTHY E MILLER
(b) Address WOODSTOCK - MD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-20-47 (month) (day) (year)
(c) Cemetery or crematory ST JOHNS
Location ELLICOTT CITY - MD

18 (a) Funeral director EDW. S. MACNABB
(b) Address CATONSVILLE - MD

19 (a) (b)
FEB 25 1947 (Date received by Registrar) Huntington Williamsport Md

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 2/17 1947 at 1.56 PM

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2/14 1947 to 2/17 1947 and that I last saw HER alive on 2/17 1947

Immediate cause of death CARDIA - RESPIRATORY FAILURE — Duration 9 DAYS

Due to DEHYDRATION AND ACIDOSIS

Due to VOMITING AND DIARRHEA

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles W. Stewart Jr. M. D.
Address MD. GEN. HOSPITAL Date signed 2/17/47

G48965

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

61

G48965 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument
(c) Hospital or institution: Sinai Hospt 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2032 E. Fairmount
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anna Fine

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | M |

6 (b) Name of husband or wife Hyman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER
12. Name Isaac
13. Birthplace Russia

MOTHER
14. Maiden Name Coby
15. Birthplace Russia

16 (a) Informant Husband
(b) Address

17 (a) Burial (b) Date thereof 2-25-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Old Fairmount Hill Rd
18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 (a) FEB 27 1947 (b) Registered

Twentyfour Hundred

V S 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 2-25 1947 at 1 A. M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2-23 1947 to 2-25 1947 and that I last saw her alive on 2-24 1947

Immediate cause of death Hypertensive - Cardio-Vascular Disease — Duration

Due to — Duration

Due to — Duration

Other Conditions Diabetes Mellitus — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

**23.** Signature Nathan B. Hyman M. D.
Address Sinai Hospital Date signed 2-25-47

927

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

038966 ✓ 879 Registered No. 038966

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution: Mt Sinai Hosp 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore 8
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 Bank St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Bessie Fisher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 54 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER 12. Name Meyer

13. Birthplace Russia

MOTHER 14. Maiden Name Ida

15. Birthplace Russia

16 (a) Informant Hyman Caplan

(b) Address 1616 No Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-25-47 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Philp Rd & Hamilton Ave

18 (a) Funeral director Lucky Levin Inc

(b) Address 1429 E Biddle St

19 (a) Date rec'd by registrar 2-25 1947 (b) Registrar

Huntington Woods

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 2-25-1947, at 4 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2/3 1947 to 2/24 1947 and that I last saw h[illegible] alive on 2/24 1947.

Immediate cause of death: Acute Cerebral Hemorrhage — Duration

Due to: Cerebral Sclerosis

Due to: Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

**23. Signature** A. L. Hamstein M. D.

Address 733 Augusta St Date signed 2/25/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G18967

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

937

Registered No. G18967

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Pall Mall Rd + Shirley Ave
(c) Hospital or institution: Mt Carmel Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Anne Arundel
(c) City or town ~~Pasadena~~ Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 Archwood Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Auslander

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | W |

6 (b) Name of husband or wife Meyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Michael
13. Birthplace Russia

MOTHER
14. Maiden Name Reba
15. Birthplace Russia

16 (a) Informant Mrs. Reba Brooks
(b) Address Annapolis Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-25-47 (month) (day) (year)
(c) Cemetery or crematory Location Hebrew Mt Carmel Cem

18 (a) Funeral director Jack Leon Levin
(b) Address 2100 Eutaw Place

19 (a) FEB 27 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2-24- 1947 at 9:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1945 to Feb. 24 1947 and that I last saw ~~her~~ alive on Feb. 24 1947

Immediate cause of death Chron. Myocarditis — Duration 2 Days
Due to Embolism — 1 Hr
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jack Leon Levin
Address 2140 Eutaw Date signed 2/27/47

VS 150

G18968

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46B

Registered No. G18968

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2333 Calverton Hgts. Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2333 Calverton Hgts. Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** JOHN J. KAMMER, Sr.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| None | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Margaret A. Kammer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 9 | 1 | hr. min. |

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Cheese Merchant - retired
11. Industry or business Self

FATHER
12. Name Thomas Kammer
13. Birthplace Germany

MOTHER
14. Maiden Name Cecelia Buchal
15. Birthplace Germany

16 (a) Informant Mrs. Margaret A. Kammer
(b) Address 2333 Calverton Hgts. Ave.

17 (a) Burial (b) Date thereof 2/26/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 25 1947 (b) Thornton Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 23, 1947 at 8:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1938, to February 1947, and that I last saw him alive on February 22, 1947

Immediate cause of death: Carcinoma of stomach with metastases — Duration: 1944-1947

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Daniel J. Schwartz M.D.
M. D.
Address 2320 Eutaw Place Date signed 2/25/47

G48969

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48969 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 935 N. Bentalou St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 935 N. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES C. BISHOP

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 215-03-3641

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Mae H. Bishop (nee Bayliss) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 19, 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 11 | 3 | hr. min. |

9. Birthplace Norfolk, Va.
(Town, county, and state)

10. Usual Occupation Packer

11. Industry or business A. & P. Stores

FATHER
12. Name James Bishop
13. Birthplace Norfolk, Va.

MOTHER
14. Maiden Name Leanore Diggs
15. Birthplace Norfolk, Va.

16 (a) Informant Mrs. Mae H. Bishop
(b) Address 935 N. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/25/47 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 130

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22, 1947, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1940, to February 1947, and that I last saw him alive on February 21, 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral embolus | |
| Due to Hypertension | 12yrs. |
| Due to Generalized ateriosclerosis | 12 yrs. |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dawne J. Silverstein M. D.
Address 2320 Eutaw Place Date signed 2/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48970

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G48970

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Green and Redwood
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 5819 Ethelbert Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs. Mabel Shoul

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | no |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife Samuel Charles Shoul — 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 1 | 28 | hr. min. |

9. Birthplace Md. (Baltimore) (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Edward Ray
13. Birthplace Scotland

MOTHER
14. Maiden Name Annie Fishpaw
15. Birthplace Md.

16 (a) Informant Mrs. Samuel C. Shoul, husband
(b) Address 5819 Ethelbert Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 26 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 24, 1947, at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 21, 1947 to Feb. 24, 1947 and that I last saw h[illegible] alive on Feb. 24, 1947

| Immediate cause of death | Duration |
|---|---|
| Cardio. resp. failure. | |
| Due to Congestive Heart failure | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Coroners exam + verdict

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Edwin R. Jennings M. D.
Address Date signed

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

048971 048971

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 701 Scott St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 Scott St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** STEWART WILKINSON EHRHART

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | no |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Loretta Vivian Ehrhart (nee Caldwell) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1893

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | 7 | 10 | hr. min. |

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Tavern Owner
11. Industry or business Self

FATHER
12. Name John Harvey Ehrhart
13. Birthplace unknown

MOTHER
14. Maiden Name Katherine Mitchell
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Loretta V. Ehrhart wife
(b) Address 701 Scott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 2-27-47 (Date Rec'd by Registrar) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 24, 1947 at 3:40A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to 2/23 1947 and that I last saw h[illegible] alive on 2/23 1947

Immediate cause of death Cerebral Thrombosis - with
Pt. hemiplegia

| Duration |
|---|
| 5 months |

Due to

Due to Coma

Other Conditions Coronary Thrombosis 1945

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. D. Ellison M. D.
Address 107 E. West St. Date signed 2/27/47

E. D. Ellison 83B

VS 150

G48972

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

131a 3

Registered No. 48972

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1919 N. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** CHRISTIAN TELFORD LOW

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Josiah Green Low
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1864

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | 11 | 22 | hr. min. |

9. Birthplace Crambington, England
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Josiah Green Low
(b) Address 1919 N. Bentalou St.

17 (a) Burial (b) Date thereof 2/26/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) FEB 25 1947 (b) Huntington Williams
(Date received by Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 24, 1947 at 7:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 20 1947 to Feb 24 1947 and that I last saw her alive on Feb 22 1947

Immediate cause of death — Respiratory failure
Due to Arteriosclerotic hypertensive Cardio vascular renal disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. Shorb M.D.
Address 601 N. Broadway Date signed 2-24-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G48973 Registered G48973

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md General Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10d
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 622 George St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Blanche Downs

3 (b) If veteran, name war

3 (c) Social Security Account No. None

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C. | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 10 | 4 | hr. min. |

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Moore

(b) Address 2837 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 26, 1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Hall & Sons

(b) Address 1617 Druid Hill Ave

19 (a) (Date received by registrar) (b) FEB 25 1947 Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/20 1947, at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.

Date signed 2/20/47

X

C48974

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 148a

C48974 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2431 Madison Ave
(c) Hospital or institution:
13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2431 Madison Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lillian Brownley

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Charles A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1899

8. AGE: Years 47 | Months 11 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Charles A. Brownley
(b) Address 2431 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 25, 1948 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lounge St. Holland
(b) Address 1631 Druid Hill Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

FEB 25 1948

V S 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 2-22- 1947, at 9 P. M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 11-1- 1946, to 2-22- 1947 and that I last saw h[illegible] alive on 2-22- 1947

| Immediate cause of death | Duration |
|---|---|
| Cancer Cervix | 1½ yrs. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Grace E. Harris M. D.
Address 2340 Madison Av. Date signed 2-25-48

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48975

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 469

Registration No. G48975

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 521 N. Mosher St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 521 N. Mosher St (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Albert H. Peck.

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Senora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1866

8. AGE: Years 80 | Months 10 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name Nathaniel Peck
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Caroline Mayfield
15. Birthplace Gettysburg, Pa.

16 (a) Informant Mrs. Virgie M. Peck
(b) Address 521 N. Mosher St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 25, 1947 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Memorial Park
Location Baltimore Co., Md.

18 (a) Funeral director George H. Holland
(b) Address 631 Druid Hill Ave.

19 (a) FEB 25 1947 (b)
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 21 Feb. 1947, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1 Sept. 1946 to 21 Feb. 1947, and that I last saw him alive on 21 Feb. 1947

| Immediate cause of death | Duration |
|---|---|
| Hypostatic pneumonia | 2 days |
| Due to Carcinoma of pancreas | 6 mos. |
| Due to | |
| Other Conditions Hyperglycemia | 6 mos. |

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James D. Carr M. D.
Address 505 Gilmor St Date signed 2-24-47

V S 150

Huntington Williams, inc.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48976 510490

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 30

Registered No. G48976

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Division St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Jennings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Ethel Jennings
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-5-85

8. AGE: Years 61 | Months 11 | Days 18 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Jennings
13. Birthplace Va

MOTHER
14. Maiden Name Lou Fitzgerald
15. Birthplace Va

16 (a) Informant Mrs Ethel Batchelor
(b) Address 1208 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 25 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto, Md.

18 (a) Funeral director Lawrence A. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23, 1947 at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 22 1947 to Feb 23 1947 and that I last saw h alive on Feb 23 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardiac decompensation | 3 mo |
| Due to Endocarditis, subacute bacterial | 1 yr |
| Due to | |
| Other Conditions Luetic aortitis | 10 yrs |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E. Mason M. D.
Address Johns Hopkins Hosp. Date signed 24 Feb '47

VS 150

Huntington Williams, M.D.

91a

G48977

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1310

G48977 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 220 N. Schroeder St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 220 N. Schroeder St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Jane Adams

3 (b) If veteran, name war — 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Col. | Married |

6 (b) Name of husband or wife: William H. Adams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 5 | | hr. min. |

9. Birthplace Harundal Co. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER — 12. Name John Griffin
13. Birthplace Md.

MOTHER — 14. Maiden Name Mary
15. Birthplace Md.

16 (a) Informant William H. Adams
(b) Address 220 N. Schroeder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 25 1947 (month) (day) (year)
(c) Cemetery or crematory W. Laurel Cem
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) FEB 25 1947 (Date rec'd by registrar) Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 22 1947 at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to Feb 22 1947, and that I last saw h[illegible] alive on Feb 21 1947.

Immediate cause of death — Duration

Cardio-vascular-Renal disease (Hypertension) — 6 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Laurel M. D.
Address 600 N. Arlington Ave Date signed Feb 24 47

VS 150

Dr. Singewald
1613 N. North Avenue

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

52a

Registered No. C18978

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5907 Greenhill Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5907 Greenhill Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Peter Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Anna Marie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 3, 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 11 | 21 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Mary ?
15. Birthplace Md.

16 (a) Informant Mrs. Anna M. Smith
(b) Address 5907 Greenhill Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 25 1947 Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24, 1947, at 11 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 3, 1947 to Feb. 24, 1947 and that I last saw him alive on Feb. 24 1947

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of left kidney & General Metastases. | 6 Mos. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Singewald M. D.
Address 1613 N. North Ave. Date signed 2-25-47

X

G48979

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G48979

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4614 Hurley Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4614 Hurley Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Rose E. Gargiulo

3 (b) If veteran, name war:

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife John Gargiulo

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 12 - 1903

8. AGE: Years 43 | Months 11 | Days 12 | If less than one day ....hr. ....min.

9. Birthplace Balto - Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Vincent Trapani
13. Birthplace Italy

MOTHER
14. Maiden Name Frances -
15. Birthplace Italy

16 (a) Informant Mr. John Gargiulo
(b) Address 4614 Hurley Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) FEB 25 1947 (Date rec'd by registrar) (b) Livingston Williams Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/24/47 19.... at 1:00 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work?
(d) Means of injury

23. Signature John P. Weiss, M.D. Medical Examiner.
Date signed 2/25/47

G48980

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V131a

G48950 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 925 N. Durham St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 925 N. Durham St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rocheal Cozy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Fmail

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Thomas Cozy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/22/1878

8. AGE: Years 69 | Months 1878 Feb | Days 22 | If less than one day hr. min.

9. Birthplace macon Ga.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Davis
13. Birthplace macon Ga

MOTHER
14. Maiden Name Mary Davis
15. Birthplace macon Ga.

16 (a) Informant John Cozy
(b) Address 925 N. Durham St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 27 1947 (month) (day) (year)

(c) Cemetery or crematory Laural cemetery
Location Baltimore

18 (a) Funeral director Lottie Gross
(b) Address 1408 Ashland Ave

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 25 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/22 1947, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/9 1946 to 2/22 1947 and that I last saw h.r alive on 2/19 1947.

Immediate cause of death: Hypertensive cardio-renal disease — Duration: 5 yrs

Due to:

Due to:

Other Conditions arterio-sclerosis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rayner Browne M.D.

Address 1500 E. Madison St Date signed 2/25/47

Rayner Browne M

G48981 Md. County
Mar 9109

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1210

G48981

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5708 Falls Road.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5708 Falls Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John F. Schaffman.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | married. |

6 (b) Name of husband or wife Carrie Schaffman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1871

| 8. AGE: Years | Months | Days | If less than one day: hr. | min. |
|---|---|---|---|---|
| 75 | 6 | 11 | | |

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Stonemason.
11. Industry or business Retired.

FATHER 12. Name Benjamin F. Schaffman.
13. Birthplace Pa.

MOTHER 14. Maiden Name Elizabeth Harman.
15. Birthplace Ireland.

16 (a) Informant Albert M. Schaffman.
(b) Address 5708 Falls Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 25 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion.
Location Forestdale Md.

18 (a) Funeral director Schumacher & Sons
(b) Address 345-17 Eastern Ave.

19 (a) FEB 25 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 21, 1947; at 10 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1947 to Feb 21 1947, and that I last saw h[illegible] alive on Feb 21 1947.

| | Duration |
|---|---|
| Immediate cause of death: Chronic Interstitial Nephritis | 7 |
| Due to: Arteriosclerosis | ? |
| Due to: | |
| Other Conditions: Hypostatic Congestion | ? Days |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. M. Dorsey M.D.
Address 517 Medical Arts Bldg. Date signed 2/25/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48982 Baltimore City

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G48982

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4212 Parkmont Ave.
(c) Hospital or institution:
Parkmont Nursing Home.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3551 Sweet Air St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Wilhelm W. Kleb.

3 (b) If veteran, name war

3 (c) Social Security Account No. 216 16 4685 A

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widower |

6 (b) Name of husband or wife Sarah E. Kleb
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 25, 1864

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | - | 29 | hr. min. |

9. Birthplace Vermont.
(Town, county, and state)
10. Usual Occupation Retired.
11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace Unknown.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Unknown.

16 (a) Informant William E. Kleb.
(b) Address 4212 Arizona Ave.

17 (a) Burial (b) Date thereof Feb 26/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Cheroweth & Donovan
(b) Address 3615 17 Chestnut Ave.

19 (a) FEB 25 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 23 19 47 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1947 to Feb. 23 1947 and that I last saw him alive on 19 at

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | 3 |
| Due to | |
| Due to | |
| Other Conditions Arteriosclerotic Cardio-Vascular Disease | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. B. Stevens M.D.
Address 4400 Edmondson Ave Date signed 2/24/47

VS 150

2727 St Paul

G48983

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 92E

Registered No. G48983

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3634 Roland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3634 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary L. Ebersole

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed. |

6 (b) Name of husband or wife Frank Ebersole.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 9 | 1 | hr. min. |

9. Birthplace Maryland.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Columbus Sykes.
13. Birthplace Md.

MOTHER
14. Maiden Name Pauline Martin.
15. Birthplace Md.

16 (a) Informant Pauline A. Martin.
(b) Address 3634 Roland Ave.

17 (a) Burial (b) Date thereof 2-28-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Paul's.
Location Arcadia, Md.

18 (a) Funeral director Chenoweth & Donovan.
(b) Address 3615-17 Chestnut Ave.

19 FEB 25 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 24, 1947, at 3.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1934, to Feb 24 1947, and that I last saw h[illegible] alive on Feb 24 19 47

Immediate cause of death (Primary - Carcinoma of Breast
Due to Primary - Carcinoma of Liver
Due to
Other Conditions
(Include pregnancy within 3 months of death)

| Duration |
|---|
| 3 days |
| 9 yrs. |

Date of operation
Major findings of operation:
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert M. Foster
Address 2824 St. Paul St. Date signed Feb 25 '47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C48984

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. C48984

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 302 S. Stiles st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** William H. Nally

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-07-9898

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| male | white | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26 1867

| 8. AGE Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 8 | 27 | hr. min. |

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation House Steward

11. Industry or business Bynum House Restaurant

FATHER 12. Name Thos. H. Nally

FATHER 13. Birthplace Wales Md

MOTHER 14. Maiden Name Sarah E. Magruder

MOTHER 15. Birthplace Va.

16 (a) Informant Leonard A. Dreed

(b) Address 6 Wadsworth Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 25 '47 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Baltimore, Md

18 (a) Funeral director F. D. Wippert, Sons

(b) Address 850 W. Baltimore St.

19 (a) Feb 25 1947 (b) Registrar Huntington Williams, M.D. Registrar

VS 181

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 2/22 1947, at 6 P M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

**IMMEDIATE CAUSE OF DEATH** Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walden, M.D. Medical Examiner.
Date signed 2/24/47

X

G48985 BCH G69600 BALTIMORE CITY HEALTH DEPARTMENT G48985
Registered No. 107

# CERTIFICATE OF DEATH

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1024 Sterling St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Bernard Moore

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | |

6 (b) Name of husband or wife Feb. 25 47
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 2/2/47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 21 | hr. min. |

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Bernard Moore Sr.
13. Birthplace Md.

MOTHER
14. Maiden Name Cora Harris
15. Birthplace N. Car.

16 (a) Informant Bernard Moore Sr.
(b) Address 1024 Sterling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 25 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Balto. County Md.

18 (a) Funeral director Mrs. Ella M. Carter
(b) Address 1539 N. Carey St.

19 (a) FEB 25 1947 (Date rec'd by registrar) Huntington Williams Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1947, at 10 a.m.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia, left
Respiratory infection
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Worden M.D. Medical Examiner.
Date signed 2-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G48986

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 124 B G48986

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Cornell St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** VIRGIE CHASE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1915

8. AGE: Years 32 | Months | Days | If less than one day hr. min.

9. Birthplace A.A.Co.Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Chase
13. Birthplace Md.

MOTHER
14. Maiden Name Ethel Howard
15. Birthplace Md.

16 (a) Informant James Chase
(b) Address 1041 W.Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James A Hayes
(b) Address 142 Garfield St

19 (a) FEB 25 1947 (Date rec'd by Registrar) (Signature of Registrar) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23, 1947, at 8.15 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute dilatation of heart
Emphysema, congestion, edema of lungs
DUE TO Acute fatty liver

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 2-26-47

VS 151

X

G48987

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13B

Registered No. G48987

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2 W
(c) Hospital or institution: South Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 171 McKeown Alley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Martha Carter

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | Married |

6 (b) Name of husband or wife Charles Carter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1915

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 32 | | | hr. min. |

9. Birthplace Alexandria, Va
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Jamie Slaton
15. Birthplace Va

16 (a) Informant Charles Carter
(b) Address 830 Poplar St

17 (a) Burial (b) Date thereof 2-27-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James A Hayes
(b) Address 142 W Pratt St

19 (a) FEB 25 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/24 1947, at 6:00 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary tuberculosis.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Taliaferro M.D.
Medical Examiner.
Date signed 2-25-47

VS 151

G48988

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

Registered No. G48988

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3 D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 832 S. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Daly

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: John Daly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years: 64 | Months | Days | If less than one day: hr. min.

9. Birthplace Ireland (Town, County, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER
12. Name Delaney
13. Birthplace Ireland

MOTHER
14. Maiden Name ?
15. Birthplace Ireland

16 (a) Informant Mrs. Daly
(b) Address 832 S Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 26/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Fred W. Orazemski
(b) Address 1930 Eastern Ave

Filed 2-25-1947 (Date filed by the registrar)

Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23, 1947, at 11 p.m.

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of left breast with metastases

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mallinckrodt M.D.
Medical Examiner.
Date signed 2-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48989

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G48989

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 705 Cator Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 705 Cator Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** GEORGE E. HOLTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Anna M. Holter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | - | - | hr. min. |

9. Birthplace Bradshaw, Md.
(Town, county, and state)
10. Usual Occupation Motorman
11. Industry or business Balto., Transit

FATHER
12. Name William P. Holter
13. Birthplace Penn.

MOTHER
14. Maiden Name Mary Weis
15. Birthplace Bradshaw, Md.

16 (a) Informant Mrs. Anna M. Holter
(b) Address 705 Cator Avenue

17 (a) Burial (b) Date thereof 2/26/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Marie
Location Towson, Md.

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVE & 22ND

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

FEB 25 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22nd 1947, at 6:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1947 to Feb. 22 1947
and that I last saw him alive on Feb. 20, 1947

| Immediate cause of death | Duration |
|---|---|
| Acute heart failure | 2 hours |
| Due to Chronic myocarditis | 2 years |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Adam J. Lucas M. D.
Address 6232 Belair Rd. Date signed Feb. 24, 1947

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JL - 106867 C18990

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

104

Registered No. C18990

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4214 Bayonne Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Julia Merryman

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife Richard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16, 1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 6 | 8 | hr. min. |

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation AT HOME.
11. Industry or business

FATHER
12. Name John Calaher
13. Birthplace ?

MOTHER
14. Maiden Name Julia Stout
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (b) Date thereof 2/27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location CITY
18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT AVE & 22ND ST.
19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150 FEB 25 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 24 1947, at 8.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 22 1947 to Feb. 24 1947 and that I last saw her alive on Feb. 24 1947

Immediate cause of death: Lobar Pneumonia — Duration 2 days

Due to

Due to

Other Conditions Obesity, marked
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Acute splenic tumor.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund S. Beacham

Address Balto City Hosp Date signed 24 Feb 47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48991

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V94a

Registered No. G48991

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2340 Annapolis Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2340 Annapolis Road (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Agnes M. Richardson

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | W | widow |

6 (b) Name of husband or wife Wm. Richardson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 11 | 20 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Nancy P. Manakee
(b) Address 2605 St Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 27/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem. Co.
Location Gwynn Oak ave

18 (a) Funeral director John O. Mitchell Est.
(b) Address 19 E Eager St

19 (a) Received this certificate FEB 25 1947 (b) Interment, removal, or cremation Huntingtn Pk

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 24 1947 at 11 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1946 to Feb 24 1947.
and that I last saw h[illegible] alive on Feb 24 1947

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | 1 Week |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Paul Schaefly
Address 2701 Annapolis Date signed 2/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48993 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G48992

# CERTIFICATE OF DEATH 194a

Eney

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Sts
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3009 Brighton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Walter S. Eney

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | married |

6 (b) Name of husband or wife Mabel J. Eney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/13/1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 10 | 12 | hr. min. |

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Officer Balto Nat. Bank
11. Industry or business "

FATHER — 12. Name Wm. Eney
13. Birthplace Balto

MOTHER — 14. Maiden Name Isabelle Tuttle
15. Birthplace Balto

16 (a) Informant Mabel Lark Eney
(b) Address 3099 Brighton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3501 Frederick Ave

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 FEB 25 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 24th 1947, at 6.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/24/1947 to 2/24/1947 and that I last saw h[im] alive on 2/22/1947

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure | |
| Due to Gouty osteoarthritis and myocardial infarction | 2 hrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. B. González
Address Maryland G. Hospital Date signed 2/24/47 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48993

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G48993 Registered No.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland BALTIMORE CITY.

(b) Street address 4700 HARFORD AVE.

(c) Hospital or institution: CONVALESENCE HOME.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4.YEARS

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

**2. USUAL RESIDENCE OF DECEASED:**

(a) State MARYLAND (b) County

(c) City or town BALTIMORE CITY. (If outside city or town limits, write RURAL and give town)

(d) Street No. 2402 ALLENDALE ROAD. (If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME SARAH V. RATHELL.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John A. Rathell (Deceased)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 10, 1865

8. AGE: Years 82 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business —

FATHER 12. Name George Claypoole

13. Birthplace Md.

MOTHER 14. Maiden Name Elizabeth Bramble

15. Birthplace Md.

16 (a) Informant Carroll A. Rathell (Son)

(b) Address 2402 Allendale Rd. Balto 16, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 26, 1947 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto. Md.

18 (a) Funeral director Geo. Bayard Evans

(b) Address 1405 E. Monument St. Balto. Md.

19 (a) FEB 25 1947 (b) Registrar

(Date received by Registrar)

VS 150

Huntingtown, Williams, Md.

**MEDICAL CERTIFICATION** A.

20. DATE OF DEATH FEBRUARY 24 1947, at 1030 M

21. I certify that death occurred on the date above stated; that I attended deceased from JANY 16 1947 to FEBY. 24 1947, and that I last saw her alive on FEBY 24 1947.

| Immediate cause of death | Duration |
|---|---|
| CHRONIC MYOCARDITIS JANUARY | 16.1947 |
| Due to ARTERIAL SCLEROSIS. | 1946. |
| Due to | |
| Other Conditions NONE | |

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: NONE

of autopsy: NONE

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

Signature Chas P Claudius M. D.

Address 3013 ST PAUL ST. Date signed FEBRUARY 24, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G48994

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13B

G48994
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 243 Bethel Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 243 Bethel Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Tobin Dupree

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Col

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Patrice Dupree

6 (c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr.) Aug 28/911

8. AGE: Years 35 Months 5 Days 22 If less than one day hr. min.

9. Birthplace Dillon S.C. (Town, county, and state)

10. Usual Occupation Saloon

11. Industry or business

FATHER
12. Name Wilson Dupree
13. Birthplace S.C.

MOTHER
14. Maiden Name Emma Page
15. Birthplace Dillon S.C.

16 (a) Informant Patrice Dupree
(b) Address 522 E Berkley Norfolk Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/20/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn Md

18 (a) Funeral director Thos J Wilson
(b) Address 1000 Eastly ave

19 (a) FEB 25 1947 (Date received by Registrar) (b) Huntington Williams Md Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 1947 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1947 to Feb 21 1947, and that I last saw him alive on Feb 18, 1947

Immediate cause of death Atypical Pneumonia — Duration 1 W.

Due to

Due to

Other Conditions Pulmonary T.B.C — Duration 3

(Include pregnancy within 3 months of death)

PHYSICIAN

Underline the cause to which death should be charged statistically.

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1412 29 Place Date signed 2/20/47

G18995 Birth Certificate D: 71409

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 160c

G18995 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
Md.
(a) State (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2119 Maryland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby boy Raynes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: hr. 10 min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Clarence David Raynes
13. Birthplace Virginia

MOTHER 14. Maiden Name Mary Evelyn Haney
15. Birthplace Baltimore, Maryland

16 (a) Informant Mary Evelyn Raynes
(b) Address 2119 Maryland Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 25 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 25 1947 (Registrar) Huntington Williams M.D.

VS 180

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1947, at 12:55 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1947 to 19; and that I last saw him alive on Feb 23 1947.

Immediate cause of death: Cardio-Respiratory failure — Duration: 10 min
Due to: Atelectasis
Due to: Asphyxia Amniotic fluid
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Tommasello M.D. M.D.
Address 910 W. Lombard Date signed 24 Feb 47

X

G48996 Birth Certificate G-71850

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 157M

Registered No. G48996

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1213 Light St. Blk 30.
(c) Hospital or institution South Baltimore Gen'l Hosp. W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (26)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Cypress St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Shirley Ann Brzozowski

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| — | — |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | S |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 19 Feb. 47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 2 | hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name James Anthony Brzozowski.
13. Birthplace Baltimore MD

MOTHER
14. Maiden Name Sophie Mary Ann Wojtowicz
15. Birthplace Baltimore

16 (a) Informant (Mother)
(b) Address 1615 Cypress St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 25 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (Date rec'd by registrar) FEB 25 1947 Hamilton Williams M.D.

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 21 Feb. 1947, at 11 15 a M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 19 Feb 1947 to 21 Feb 1947, and that I last saw her alive on 21 Feb 1947.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Post-operative Shock | |
| Due to Ruptured Umbilical Hernia | |
| Due to Pyelonephritis | |
| Due to Lack of Anterior Abdominal wall - | |
| Other Conditions Repair 20 Feb 47. | |

(Include pregnancy within 3 months of death)

Date of operation 20 Feb 47
Major findings of operation: Failure of Abdominal wall.
Findings of autopsy: Same as during operation.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Cole M. D.
Address South Balt Gen'l Hosp Date signed 24 Feb 47

VS 150

G43997 BC# BALTIMORE CITY HEALTH DEPARTMENT G43997

# G71228 CERTIFICATE OF DEATH 159

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 das.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 das.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Ohio (b) County
(c) City or town Cleveland (If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 Fairview Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Girl Flinn

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | single |

6 (b) Name of husband or wife 0

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/17/47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 21 | hr. min. |

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation 0

11. Industry or business 0

FATHER
12. Name Joseph Flinn
13. Birthplace Cleveland, Ohio

MOTHER
14. Maiden Name Mary Flinn
15. Birthplace Charleston W. Va

16 (a) Informant Mary Flinn
(b) Address 1314 Fairview Cleveland Ohio

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School FEB 25 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 25 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/18 1947, at 4:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/17 1947, to 2/18 1947, and that I last saw h. alive on 2/18/ 1947.

| Immediate cause of death | Duration |
|---|---|
| Prematurity | |
| Circulatory collapse | |
| Due to 0 | |
| Due to 0 | |
| Other Conditions 0 | |

(Include pregnancy within 3 months of death)

Date of operation 0

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley B. Klyanowicz, M.D.
Address Franklin Sq. Hosp (Date signed 2/25/47)

G48998

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

8-2a

G48998 Registered No.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1034 Hanover St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore City,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1034 HANOVER ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Edna E. Plitt

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Leonard Plitt
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) July 8, 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 7 | 14 | hr. min. |

9. Birthplace Baltimore City,
(Town, county, and state)
10. Usual Occupation Housewife,
11. Industry or business at home,

FATHER
12. Name Albert Michel,
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Farber,
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Lennard Plitt,
(b) Address 1034 Hanover St.

17 (a) Burial (b) Date thereof 2/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore City.

18 (a) Funeral director L. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.

19 (a) (b)
(Date received by Registrar) (Registrar)

FEB 25 1947 Hunting for Williams

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 22, 1947 19 , at 9.40 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-26 1947 to 2/22 1947 and that I last saw her alive on 2/21 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 3 hrs. |
| Due to | |
| Due to Respiratory Failure | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Vincent M. Mesaros
Address 1403 S. Charles St. Date signed 2 M D 7/47

X

Birth Certificate
G-71822

G48999

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G48999

Registered No. 159

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where exact age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address Wilkens + Caton Aves.

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) Born here

(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2413 N Pulaski St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Girl Cross

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/25/47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | 6 hr. 2 min. |

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frances Cross
13. Birthplace

MOTHER
14. Maiden Name Sylvia Peal
15. Birthplace W. Va.

16 (a) Informant St. Agnes Hosp.
(b) Address

17 (a) Buried (b) Date thereof 2/26/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location

18 (a) Funeral director C. V. Lawrence

(b) Address 4611 Park Heights

19 (a) 1947 (b) Lurton Williams, M.D. Registrar
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 2/25 19 47, at 7:10 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2/25 19 47, to 19, and that I last saw h.e.r alive on 2/25 19 47

Immediate cause of death, Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

**23.** Signature H. D. Lenkus

Address St Agnes Hosp Date signed 2/25/47

VS 150

G49000 BALTIMORE CITY HEALTH DEPARTMENT X G45009
Registered No.

# CERTIFICATE OF DEATH 161c

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Druid St.
(c) Hospital or institution:
University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Hall's Cross
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1825 Park Avenue - x 7
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy Ellinger — Robert Lee ELLINGER

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Infant |

6 (b) Name of husband or wife infant
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-20-47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 1 | — | 4 | hr. min. |

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business —

FATHER
12. Name Guy Lee Ellinger
13. Birthplace Stanton Va.

MOTHER
14. Maiden Name Dorothy J. Fitzwaters
15. Birthplace Moorefield W. Va.

16 (a) Informant Guy Lee Ellinger
(b) Address 1825 Park Ave, Hall's Cross

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 2/26/47 (month) (day) (year)
(c) Cemetery or crematory
Location Moorefield W. Va.

18 (a) Funeral director W. J. Fickner & Sons
(b) Address Ft. Pat Aves, Balto 17, Md.

19 (a) (Date received by registrar) (b) Huntington Williams M.D.

FEB 27 1947

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb. 24 1947, at 8 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Feb 24 1947 to Feb 24 1947 and that I last saw him alive on Feb 24 1947

Immediate cause of death Prematurity
Due to failure of circulatory failure
Due to acute hemolytic crisis
Due to Erythroblastosis fetalis (?)
Other Conditions

| Duration |
|---|
| Desc birth |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23.** Signature Charles R. Lehmer M.D.
Address Univ. Hosp. Date signed 2/26/47

X

G49001

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G49001

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1405 McHenry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 1405 McHenry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Geary

3 (b) If veteran, name war None

3 (c) Social Security Account No. 714-05-6696

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Catherine A. Geary

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) July 13-1883

8. AGE: Years 63 | Months 7 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired Chauffer

11. Industry or business Rail Way Express

FATHER
12. Name James Geary
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Griffin
15. Birthplace Baltimore Md

16 (a) Informant Catherine A. Geary
(b) Address 1405 McHenry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 17 1947 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Balto Md

18 (a) Funeral director P. J. O'B. Walter
(b) Address Pratt Stricker Sts

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

FEB 26 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1947, at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/26 1945 to 2/23 1947 and that I last saw h. alive on 2/22 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration 8 M 15 D

Due to: Cardio Vascular Disease C. Hypertension — 2 Years

Due to:

Other Conditions: Cerebral Sephylis — 5 Years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elliott W. Johnson M. D.

Address 3632 Friedwald Ave Date signed

937

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49002

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46F

Registered No. G49002

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 414 Elmtree St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 414 Elmtree St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emil Kwedlicka

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife None
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1883

8. AGE: Years 63 | Months 4 | Days 5 | If less than one day ___ hr. ___ min.

9. Birthplace Europe (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER 12. Name Michael Kwedlicka
FATHER 13. Birthplace Europe

MOTHER 14. Maiden Name Marie Marek
MOTHER 15. Birthplace Europe

16 (a) Informant Mrs. Molly Walz
(b) Address 3923 Dick St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd

18 (a) Funeral director John F. Denny Sons
(b) Address 704 Light St.

19 (a) FEB 26 1947 (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23rd 1947, at 5 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1946 to 19___, and that I last saw h[illegible] alive on Feb 22 1947

Immediate cause of death Myocardial Insufficiency — Duration 2 days
Due to Carcinoma Ghiver — Duration one year
Due to
Other Conditions Ascites

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leon P. Starka M. D.
Address 3700 Reisterstown Rd. Date signed 2/27/47

VS 150 Huntington Williams, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49003

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G49003 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2709 Hugo Ave
(c) Hospital or institution:
G-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2709 Hugo Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Oscar J. Miles

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 214-03-7817

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife: Myrtle E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1-1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 1 | 22 | hr. min. |

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Supervisor
11. Industry or business Balto Transit Co.

FATHER
12. Name John W. Miles
13. Birthplace Va.

MOTHER
14. Maiden Name Julia A Hopkins
15. Birthplace Va.

16 (a) Informant Mrs Myrtle E. Miles
(b) Address 2709 Hugo Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/24/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Parkville, Balto Co.

18 (a) Funeral director Wm Cook Jr.
(b) Address 1217 St Paul street.

19 (a) FEB 26 1947 (Date received by registrar) Washington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 23 1947, at 5.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11 1946 to Feb 23 1947.
and that I last saw h im alive on Feb 23 1947

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | 6 Hours |
| Due to Coronary sclerosis | 5 yr. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Adam J Sivers
Address 6232 Belair Rd Date signed Feb 25 1947

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43001

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 61

Registered No. G43001

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 41st Stand. Gerard Ave
(c) ~~Hospital or~~ institution: Ardleigh Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2075 Rockrose Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Edward G. Moore

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-5428

| 4. Sex | 5. Color or race | 6 (a) ~~Single, married~~ widowed, or divorced |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of ~~husband or~~ wife Lilly May Fick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct 6th 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 4 | 17 | hr. min. |

9. Birthplace Groveport Ohio
(Town, county, and state)
10. Usual Occupation Clerical Worker
11. Industry or business Md. Biscuit Co.

FATHER
12. Name Nathan L. Moore
13. Birthplace Ohio

MOTHER
14. Maiden Name Catherine A. Long
15. Birthplace Ohio

16 (a) Informant Mr Long
(b) Address Ohio

17 (a) Burial (b) Date thereof 2/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) FEB 26 1947 (b) Huntington Hill Registrar
(Date received by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 23rd 1947, at 2.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 21 47, to Feb. 23 1947, and that I last saw ~~he~~ alive on Feb. 21 1947

| Immediate cause of death | Duration |
|---|---|
| (a) Pneumonia | 2 days |
| Diabetes | 9 yrs |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. R. Johnson M.D.
Address 403 McCartney Date signed 2/25/47

VS 150

× By

G49005
510515

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G49005 / 157E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2907 Dunmore Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Darlene Harrison

3 (b) If veteran, name war: W
3 (c) Social Security Account No. NINE

4. Sex: Female | 5. Color or race: White | 6 (a) Single, ~~married, widowed, or divorced~~: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 26th 1943

8. AGE: Years: 3 | Months: 11 | Days: 28 | If less than one day: hr. min.

9. Birthplace: Md
(Town, county, and state)

10. Usual Occupation:
11. Industry or business:

FATHER
12. Name: George Harrison
13. Birthplace: Md

MOTHER
14. Maiden Name: Barbara Bugtinson
15. Birthplace: Pa.

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, ~~cremation, or entombment~~) (b) Date thereof 2/26/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Morland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) FEB 26 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24 1947, at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 23 1947, to Feb. 24 1947 and that I last saw h~~e/she~~ alive on Feb 24 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure | |
| Due to Congenital Heart Disease (? truncus arteriosus) | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Barton Childs
Address Johns Hopkins Hosp. Date signed 2 M.D.

Spec.—1-10-21—M&T—1500 Blks.

G49006

# HEALTH DEPARTMENT—CITY OF BALTIMORE

G49006

## CERTIFICATE OF DEATH.

1-PLACE OF DEATH Kernan Hospital - Baltimore 7, Md.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ..... WARD)

2-FULL NAME INGRID ROUZER

(a) RESIDENCE NO. 728. E. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. dys. How long in U. S., if of foreign birth? yrs. mos. dys.

### PERSONAL AND STATISTICAL PARTICULARS

| 3 SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word) |
|---|---|---|
| Female | white | single |

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 3, 1943

| 7 AGE | Years | Months | Days | If LESS than 1 day, ....hrs. or ....min. |
|---|---|---|---|---|
| | 3 | 7 | 22 | |

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New York
(State or country) N. Y.

PARENTS

10 NAME OF FATHER William Rouzer

11 BIRTHPLACE OF FATHER (city or town) Altoona
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Alberta Craver

13 BIRTHPLACE OF MOTHER (city or town) Cambria Co.
(State or country) Pa.

14 Informant Thomas Craver
(Address) 728 E. Biddle St

15 Filed FEB 26 1947 Huntington Williams M.D. Registrar

### MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25, 1947

17 I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1946 to Feb. 25 1947.

that I last saw her alive on Feb. 25 1947.

and that death occurred, on the date stated above, at 5.05 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis meningea

(duration) 0 yrs. 1 mos. 11 dys.

CONTRIBUTORY (Secondary) Tuberculosis of 3rd & 4th lumbar vertebrae

(duration) 0 yrs. 6 mos.? dys.

18 Where was disease contracted if not at place of death? at home - mother

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J. Ralph Pribram M. D.

, 19 (Address) Kernan Hospital, Balto. 7, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 ~~PLACE OF BURIAL, CREMATION OR~~ REMOVAL Carrolltown Pa.

DATE OF BURIAL 2/27 1947

20 UNDERTAKER William Cook Inc

ADDRESS 1217 St. Paul St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43007

CWK-108669

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1222a

Registered No. G43007

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 Hrs.
88- 2- 13-
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4704 Harford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Louise Malloy

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12-1858

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 88 | 2 | 13 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER: 12. Name John F. Malloy
13. Birthplace Maryland

MOTHER: 14. Maiden Name Fannie Sollers
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 2/27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) FEB 26 1947 (b) Washington Williams, Registrar
(Date rec'd by registrar)

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH February 25 19 47, at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 24 19 47 to Feb. 25 19 47, and that I last saw h. alive on Feb. 25 19 47.

| Immediate cause of death | Duration |
|---|---|
| Cerebral vascular accident | 12 hrs |
| Due to Intestinal obstruction | 24 hrs |
| Due to Femoral hernia | ? |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 2-24-47
Major findings of operation: as above
of autopsy: 0

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Lamon Jowell M. D.
Address Balto. City Hosp. Date signed 2-25-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43008

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G43008

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lexington St
(c) Hospital or institution: Fayette Nursing Home 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1635 Walpert. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Etta Bontrum

3 (b) If veteran, name war W

3 (c) Social Security Account No. NONE

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | W. | Single. |

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 19, 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 Years | 10 | 4 | hr. min. |

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name John Bontrum
13. Birthplace Md

MOTHER
14. Maiden Name Mary (Unknown)
15. Birthplace " "

16 (a) Informant Mrs. Irma L. Harris
(b) Address 327 St. Paul Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto Md

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) Date received by registrar FEB 26 1947 (b) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1947, at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1947 to Feb 23 1947 and that I last saw h[illegible] alive on Feb 23 1947

| Immediate cause of death | Duration |
|---|---|
| General Arteriosclerosis | 10 yrs |
| Chronic Myocarditis | 10 yrs |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nelson L. Solomon M. D.
Address 129 E Burley Date signed Feb 23, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(43009)

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

(43009) 126

Registered No. .....

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Broadway and Fairmount
(c) Hospital or institution:
Church Home and Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1273 East North Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Ione Louise Resau

3 (b) If veteran, name war No

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Preston A. Resau

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 22, 1887

8. AGE: Years 59 | Months 7 | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER 12. Name John Ramey

13. Birthplace Baltimore

MOTHER 14. Maiden Name Ella Hollingshead

15. Birthplace Baltimore

16 (a) Informant Patient

(b) Address above

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 27th. (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem

Location Rural

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2005 Orleans St

19 (a) FEB 26 1947 (Date received by registrar)

Huntington Williams, M. D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 24 1947 at 12:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from February 1947 to February 24 47 and that I last saw her alive on Feb 24 1947

Immediate cause of death Uremia — Duration 10 days

Due to Hepato-Renal failure, post-operative — 8-10 mos.

Due to Cholelithiasis and Cholecystitis

Other Conditions Biliary Obstruction

(Include pregnancy within 3 months of death)

Date of operation February 5 1947

Major findings of operation: Biliary obstruction

of autopsy: Biliary Obstruction

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: No

(a) Accident, suicide, or homicide No

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....

(e) Means of injury .....

23. Signature H. J. Fohlerman M. D.

Address Church Home Hosp. Date signed 24 Feb 47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

64010

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. 64010

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 812 Whitmore Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 101 N. Janney St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John William Smith

3 (b) If veteran, name war: No

3 (c) Social Security Account No. No

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna May Smith

6 (c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1891

8. AGE: Years 55 | Months 4 | Days 29 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Penn. Railroad

11. Industry or business:

FATHER
12. Name: Christian M. Smith
13. Birthplace: Maryland

MOTHER
14. Maiden Name: ?
15. Birthplace:

16 (a) Informant: Mrs. Anna May Smith
(b) Address: 101 N. Janney St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-47 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill
Location: ANNE ARUNDEL County Md.

18 (a) Funeral director: Geo. W. Little
(b) Address: 2700 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Registrar: Lexington Williams

VS 15 FEB 26 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 24 1947, at 6.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-8-1947 to 2-24-1947. and that I last saw h[illegible] alive on 2-24-1947.

Immediate cause of death: Dilatation of Heart

Due to: Coronary Thrombosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

| Duration |
|---|
| unknown |
| unknown |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Chester Riland, M. D.
Address 2532 Edmondson Av. Date signed 2-25-47.

X

G43011 HEALTH DEPARTMENT—CITY OF BALTIMORE G43011

CERTIFICATE OF DEATH 185

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 Dolphin St. Ward) 17

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Charles Edward Gaar

If U. S. Veteran specify WAR

(a) Residence: No. 524 Dolphin St. Ward.

(Usual place of abode) (If non-resident give city or town and State)

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE absolutely must be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. Color or Race | 5. Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| M | W | Single |

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day, year) March 2 - 1907

| 7. AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 39 Yrs | 11 | 0 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Invalid

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —

10. Date deceased last worked at this occupation (month and year) 1946

11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) (State or country) Balto Md

FATHER

13. NAME James Gaar

14. BIRTHPLACE (city or town) (State or country) Md

MOTHER

15. MAIDEN NAME Rachel Darnell

16. BIRTHPLACE (city or town) (State or country) Md

17. INFORMANT Mrs William Henry

(Address) 5 Woodbridge St

18. BURIAL, CREMATION, OR REMOVAL

Place Burial Date 2-26 1947

19. UNDERTAKER George P. Gilson & Son

(Address) 1133 Druid Hill Ave

20. FEB 26 1947 Washington Wm Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Feb 22, 1947

22. I HEREBY CERTIFY, That I attended deceased from Oct 22, 1946 to Feb 22 1947

I last saw him alive on Feb 20 1947 Death is said to have occurred on the date stated above, at 12 P.M.

The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Epilepsy | |
| | |
| | |

Other contributory causes of importance

| | |
|---|---|
| Headaches | |
| | |

Was an operation performed? No Date of

For what disease or injury?

Name of operation —

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Howard Hanson Jones M. D.

(Address) 1722 Druid Hill Ave

VS 5

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49012

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

G49012 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3205 Fairfield Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs.) mos., or days) 25

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto city
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3205 Fairfield Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha A. Ware

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/3/1895

8. AGE: Years 51 | Months 9 | Days 21 | If less than one day hr. min.

9. Birthplace A. A. Co. Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Green
13. Birthplace md

MOTHER 14. Maiden Name Maggie Johnson
15. Birthplace Md

16 (a) Informant Joseph Ware
(b) Address 3205 Fairfield Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 109 W Montgomery St

19 (Date rec'd by registrar) FEB 26 1947 Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/24/47 at 12 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7 1946 to Feb 22 1947 and that I last saw h.. alive on Feb 22 1947

Immediate cause of death Hypertensive type heart disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Evan H. Bickel, M.D.
Address 100 N. Calhoun Date signed 2/24/47

G48013

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G48013

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 104 N. Fremont Ave
(c) Hospital or institution: 18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 N. Fremont Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** ARTHUR WRIGHT

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) 8/15/1895

8. AGE: Years 51 | Months 6 | Days 6 | If less than one day ____hr. ____min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Wm. Wright
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Eliza Bell
15. Birthplace Baltimore, Md.

16 (a) Informant Mary Wright (Wife)
(b) Address 104 N. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 E. Carrollton Ave

19 (a) 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

FEB 26

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/21/47 19____, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17 1947 to 2-21 1947 and that I last saw h[illegible] alive 2-21 1947.

Immediate cause of death: Cerebral Hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 7 hrs.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. H. Wright M. D.

Address 5157 Belmont Ave Date signed Feb 27 1947

X

G49014

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1927

Registered No. G49014

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1930 E. FAIRMOUNT AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 y
(e) Length of stay in Baltimore (yrs., mos., or days) 41 YRS

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1930 E. FAIRMOUNT AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME TILLIE BASHEFSKY — (ROSEN)

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | W |

6 (b) Name of husband or wife JOSEPH
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 (72) | | | hr. min. |

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name NOT KNOWN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace RUSSIA

16 (a) Informant SONIA MEYERS
(b) Address 1930 E. FAIRMOUNT AVE

17 (a) BURIAL (b) Date thereof 2-26-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location PHILA. PK. HAMILTON AVE

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St. Williamsport Pa.

19 (a) (b) Remington for Williamsport
(Date rec'd by registrar) Registrar

FEB 26 1947

IVE. 100

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/25 1947; at 2 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 20 1947 to Feb. 25 1947 and that I last saw her alive on Feb. 25 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral Embolism | 2 days |
| Due to Arteriosclerotic Myo-Carditis + Endocarditis | 5 wks |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ernest Levin M.D.
M. D.
Address 160 N. Broadway Date signed 2/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43015

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 131a

Registered No. G43015

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland 2430
(b) Street address 2430 Jefferson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2430 Jefferson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Pankratz Scheuring

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Constantine Schauring
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1863

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 9 | 12 | hr. min. |

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name ---Scheuring
13. Birthplace Germany

MOTHER
14. Maiden Name --
15. Birthplace Germany

16 (a) Informant Constantine Scheuring
(b) Address 2430 Jefferson St.

17 (a) Burial (b) Date thereof Feb. 27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location Balto., Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 (a) (b)
(Date rec'd by registrar) (Registrar)

FEB 26 1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 24/47 19 , at 430 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mard 1943 to Feb 24 1947.
That I last saw h alive on Feb 24 19 47

| Immediate cause of death | Duration |
|---|---|
| Arteriosclerotic Cardiovascular Renal disease | several years |
| Due to Cystitis | 3 days. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address 617 Hanford Rd Date signed 2-27 47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49016

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH (937)

Registered No. G49016

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 543 N. Washington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 71 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 543 N. Washington St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Estelle Flack

3 (b) If veteran, name war: no
3 (c) Social Security Account No. —

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Henry Flack
6 (c) If alive, give age 74 years
7. Birth date of deceased (mo., day, yr.) Dec. 2, 1874
8. AGE: Years 72 | Months 71 | Days 2 | If less than one day ____ hr. ____ min. 23
9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Holmes
13. Birthplace England

MOTHER
14. Maiden Name Mary Forney
15. Birthplace Balto. Md.

16 (a) Informant May Williamson
(b) Address 543 N. Washington St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 28/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Balto Md
Location
18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St
19 (a) FEB 26 1947 (Date rec'd by registrar) Huntington Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb. 25 1947, at 5:25 PM

**21.** I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to Feb 1947, and that I last saw h[er] alive on Feb 25 1947.

Immediate cause of death: Myocardial infarction due to coronary occlusion — Duration: 5 days
Due to
Due to
Other Conditions: Hypertension, Heart Disease — Duration: 5 yrs
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sholom O. Waife M. D.
Address 244 N. Helton St Date signed 2/25/47

VS 150

X

G43017

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

61

G43017
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Rayner & Dukeland
(c) Hospital or institution West Baltimore Gen. Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2805 Winchester St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Julia A. Lerp.

3 (b) If veteran, name war: no
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Howard O. Lerp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 4 | 19 | hr. min. |

9. Birthplace Elkridge, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. A. Peddicord
13. Birthplace Md.

MOTHER
14. Maiden Name Julianna Schultz
15. Birthplace Germany

16 (a) Informant Mr. Howard O. Lerp, husband
(b) Address 2805 Winchester St.

17 (a) Burial (b) Date thereof 2/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 26 1947 (b) [illegible] for Williams, M.D.
Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 24 February 1947 at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 15 Jan 1947 to 24 Feb 1947 and that I last saw her alive on 24 Feb 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardiac Resp. Failure | |
| Due to Cerebral Hemorrhage | |
| Due to Diabetic Mellitus | |
| Other Conditions Fracture of the left femur, neck | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence Dec 7 1946 1500 Winchester St
(c) Where did injury occur? Baltimore. Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? no
(Specify type of place)
(e) Means of injury Fell down steps

23. Signature Louis A. Lerp M. D.
Address 1 E. Lake Ave. Balto. 10 Md. Date signed 2 Mar 47

C. J. Lubinski MD. / Jos. L. J. Merrill MD

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49018

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 193E

G49018 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 111 South Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Hoover

3 (b) If veteran, name war: WWI

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 31-1900

8. AGE: Years 46 | Months 6 | Days 23 | If less than one day hr. min.

9. Birthplace: Elkins, W. Va. (Town, county, and state)

10. Usual Occupation: Store Room Clerk

11. Industry or business: Bethlehem Steel Co.

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Records
(b) Address: Bethlehem Steel Co.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-41 (month) (day) (year)
(c) Cemetery or crematory: Hickory Slate
Location: Elkins W. Va.

18 (a) Funeral director: L. Howard Strong
(b) Address: 3207 W. North Ave.

19 FEB 26 1941 (Date rec'd by registrar) (b) Waiting for Williams M.D. Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1941, at 12 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute congestive cardiac failure
Due to Acute gastro-enteritis
Acute congestion of all viscera

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard Williams M.D. Medical Examiner.
Date signed 2-24-41

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB- 108616 C13019

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

108

Registered No. C13019

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Jesse Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Col. | Widowed |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-? 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 ? | ? | ? | hr. min. |

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name ? Smith
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md.

18 (a) Funeral director Geo. S. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) [illegible] (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

~~Permit to be approved by Medical Examiner~~
For S. J. B. Davis, by Honor J. Wechsler, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 22- 1947, at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-22- 1947 to 2-22- 1947 and that I last saw him alive on 2-22- 1947.

Immediate cause of death Lobar Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

| Duration |
|---|
| ? |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund Beacham

Address Balto City Hosp Date signed 24 Feb 47. M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49020

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13 B

G49020 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 796 George St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

**3 (a) FULL NAME** Mary REDDEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Colored | Married |

6 (b) Name of husband or wife Roy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-15-1921

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 25 | 10 | 11 | ....hr. ....min. |

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Roy Redden
(b) Address 793 George St

17 (a) Burial (b) Date thereof 2-27-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md.

18 (a) Funeral director Williams A. Jackson
(b) Address 916 George Avenue
Washington Williams, M.D.

19 (a) (Date received by Registrar) (b) Registrar

FEB 28 1947

VS 181

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 26 1947, at 4:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒; accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Pulmonary Tuberculosis
Fatty degeneration of liver

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 2/26/47

X

G49021

510 392

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

83a

G49021 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 720 Pennsylvania Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** David Sumner

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Black | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-8-1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 53 | 2 | 12 | hr. min. |

9. Birthplace Ala (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name David Sumner
13. Birthplace Ala

MOTHER 14. Maiden Name Mary Jackson
15. Birthplace Ala

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-1-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Bucks, Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave.

19 (a) 3-2-1947 (Date filed by registrar) (b) Clayton Williams Registrar

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 2-20- 1947 at 8:30 a M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2-20- 1947 to Feb 20, 1947 and that I last saw h[illegible] alive on Feb 20 1947

Immediate cause of death Cerebral hemorrhage — Duration 8 hrs

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23.** Signature Robert I. Mason

Address Johns Hopkins Hosp. Date signed 2-20-47

A B.

X

G19022

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G19022

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 707 Bruce St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 707 Bruce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Eliza Matthews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5 Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14, 1862

8. AGE: Years 85 | Months - | Days 14 | If less than one day hr. min.

9. Birthplace Howard Co. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Maggie Robinson

15. Birthplace Howard Co. Md.

16 (a) Informant Mrs. Mary Parker

(b) Address 707 Bruce St.

17 (a) Burial (b) Date thereof Feb 26, 1947 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland

(b) Address 631 Druid Hill Ave.

19 (a) Feb 26 1947 (Date rec'd by registrar) (b) Registrar Huntington Williams

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 19 47; at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 19 45 to Feb 24 19 47 and that I last saw her alive on Jan 20 19 47

Immediate cause of death Cardiac Vascular Disease — Duration 2 yrs

Due to Hypertension — 2 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. William Fray

Address 1928 Penna Ave Date signed M. 2 D. 26 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49023

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 150

Registered No. G49023 M-49023

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2537 Boyd St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2537 Boyd St.
(If rural give location)
(e) Citizen of foreign country? Nev (Yes or No)
If yes, name country

**3 (a) FULL NAME** Carrie St. Andreae

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Victor J.
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) 10/10/1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 4 | 13 | ____hr. ____min. |

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Jacob H. Sievers
13. Birthplace England

MOTHER
14. Maiden Name Catherine Stefan
15. Birthplace Germany

16 (a) Informant Mrs. Catherine Sievers
(b) Address 2540 Boyd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 26/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md

18 (a) Funeral director E. B. Wiplatt & Son
(b) Address 1327 Eutaw Pl.

19 (a) FEB 26 1947 (Date rec'd by registrar) (b) Huntington, West Virginia

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 23 1947 at 3:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Feb 23 1947, and that I last saw her alive on ____ 19____.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Thrombosis | 6 mos. |
| Due to Coronary Occlusion | |
| Due to | |
| Other Conditions Diabetes Mellitus | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur H. Lemmon M.D.
Address 4509 Hudson Date signed 2/25/47

V S 190

G49021

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 937

Registered No. 49021

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3444 Belair Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3444 Belair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** FANNIE OTILLA FORD

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Oliver C. Ford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 14, 1869

8. AGE: Years 77 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: William Holschur
13. Birthplace: Germany

MOTHER
14. Maiden Name: Anna ?
15. Birthplace: Germany

16 (a) Informant: Miss Marie Ford
(b) Address: 3444 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/47 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b)

FEB 26 1947

Huntington Undertaking Co

**MEDICAL CERTIFICATION** PM

20. DATE OF DEATH February 23, 47, at 10.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-28- 1947, to 2-23- 1947, and that I last saw her alive on 2-23- 1947

| | Duration |
|---|---|
| Immediate cause of death: Bronchial Asthma | 26 days |
| Due to: Myocardial degeneration | ? |
| Due to: | |
| Other Conditions: Chronic enteritis | 20 years |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Milton C. Lang M. D.
Address: 2117 Belair Rd Date signed 2-25 47

X

G19025

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

Registered No. G19025

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 410 Hathinson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 Hathinson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Emma Enson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Laurence F. Enson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 0 | 11 | hr. min. |

9. Birthplace Cockeysville Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Garrett Shroyer
13. Birthplace Baltimore Co. Md.

MOTHER
14. Maiden Name Mary Chenoweth
15. Birthplace Baltimore Co. Md

16 (a) Informant Laurence F. Enson
(b) Address 410 Hathinson Ave

17 (a) Burial (b) Date thereof 2-27-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Lorenz Bisney
(b) Address 5085 Park Heights Ave

19 (a) (b)
(Date received by Registrar) (Registrar's signature) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 25 1947, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17 1945 to Feb 25 1947 and that I last saw her alive on Feb 25 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 6 Hrs |
| Due to Arterial Hypertension | ? |
| Due to Arteriosclerosis | ? |
| Other Conditions None | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature L. E. Nichols M.D.
Address Pikesville Md Date signed Feb 26 1947

X

CWK-107674

049026

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

136

049026 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 36- 8- 10-

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1832 Bank Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Hugh Friel

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15-1910

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 36 | 8 | 10 | hr. min. |

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Dunn
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/47 (month) (day) (year)
(c) Cemetery or crematory New East Point Rd.
Location
18 (a) Funeral director E. Hellmann Son
(b) Address 6067 Harf. Rd
19 (a) (b)
FEB 26 1947 Registrar
Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH February 25 19 47, at 3:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 16 19 47 to Feb. 25 19 47 and that I last saw him alive on Feb. 25 19 47

Antecedent causes of death
(a) Pulmonary tuberculosis — Duration 3 Mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H.S. Draher M.D.
Address Baltimore City Hosp. Date signed 2-25-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G43027

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G43027 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland ✓
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: The Seton Institute
(d) Length of stay in hospital or inst. (yrs., mos., or days) 41-8-15
(e) Length of stay in Baltimore (yrs., mos., or days) unknown - at least 42 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town Texas
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Germany

3 (a) **FULL NAME** Margaret Ross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband ~~or wife~~ John Ross

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? Oct. 1865

8. AGE: Years 82 | Months unknown | Days | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name unknown

13. Birthplace unknown

MOTHER 14. Maiden Name unknown

15. Birthplace unknown

16 (a) Informant The Seton Institute

(b) Address 6420 Reisterstown Rd., Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-47 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore - Md.

18 (a) Funeral director Stewart & Mowen Company

(b) Address 108 W. North Ave. - City

19 (a) Filed (b) Rec'd by registrar Huntington Willis Registrar

FEB 26 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/25 1947, at 4 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1920 to 2/25 1947, and that I last saw h... alive on 2/25 1947

Immediate cause of death: Myocardial infarct

Due to Arteriosclerosis

Due to

Other Conditions Selerosis Thoracic Paracusis Hypertension

(Include pregnancy within 3 months of death)

Duration: 2 Weeks; 19 yrs.; 42 yrs.

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address 336 Fidelity Bldg. Date signed

G49038

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1047 G49038

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 633 - N. Franklin St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 633 - Franklin St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Emma Little

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | colored | Widow |

6 (b) Name of husband or wife Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 66 | | | hr. min. |

9. Birthplace Hadesboro, north carolina (Town, county and state)

10. Usual Occupation unemployed.

11. Industry or business

FATHER
12. Name Ned Medons
13. Birthplace north Carolina

MOTHER
14. Maiden Name Lizzie Leighman
15. Birthplace North Carolina

16 (a) Informant Samuel Little
(b) Address 633 N. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/47 (month) (day) (year)

(c) Cemetery or crematory Hadesboro, N.C.
Location

18 (a) Funeral director A. Halstead
(b) Address 916 Druid Hill Ave.

19 (a) FEB 26 1947 (Date rec'd by Registrar) (b) Victor Williams, M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 22, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1947 to Feb 22 1947. and that I last saw h[illegible] alive on Feb 24 1947.

Immediate cause of death Pneumonia — Duration 4 Weeks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 633 N. Franklin St. Date signed 2/24/47

X

G49029 | BALTIMORE CITY HEALTH DEPARTMENT | G49029 Registered No.

# CERTIFICATE OF DEATH 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1142 Dorn St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1142 Dorn St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-7-1882

8. AGE: Years 64 | Months 10 | Days 18 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William Smith
13. Birthplace Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Gertrude Cambell
(b) Address 806 McDonell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-1-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) (b) (Date rec'd by registrar) Registrar

FEB 26 1947

Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 2-25 1947, at 9:30 A/M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-15 1947, to 2-25 1947 and that I last saw h[illegible] alive on 2-22 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration
Due to: Arteriosclerosis — 14y
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Atwell Jones M. D.
Address 5 S. Eutaw St. Date signed 2-26-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49030

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G49030

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5407 Green Spring Ave.
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5407 Green Spring Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Elizabeth Thelin Turner

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | married |

6 (b) Name of husband or wife James F. Turner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 8 | 28 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name William Thelin
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Griswold
15. Birthplace Ga.

16 (a) Informant James F. Turner, Jr.
(b) Address Brooklandville, Md.

17 (a) Burial (b) Date thereof 2/27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) FEB 26 1947 Huntington Williams
(Date received by registrar) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 25, 1947, at 3.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to Feb 25 1947
and that I last saw h[illegible] alive on Feb 26 1947

Immediate cause of death
Coronary Occlusion
Due to Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration.
15 Mins
Gradual

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. D. Reedy
Address 1403 Park Ave. Date signed 2/27/47 M. D.

X

G49031

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G49031

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd St. & Guilford Ave.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 67

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2921 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Robert Glenn King

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/15/1879

8. AGE: Years 67 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Henry S. King
13. Birthplace Maryland

MOTHER
14. Maiden Name Ella Wynn
15. Birthplace Maryland

16 (a) Informant Hospital records
(b) Address 33rd & Calvert Sts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feby 27/9 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John D. Mitchell Sons
(b) Address 1600 Eutaw Place

19 (a) (Date rec'd by Registrar) (b) Registrar

FEB 26 1947 Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25, 1947, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 25, 1947 to Feb. 25, 1947, and that I last saw h. on. alive on Feb. 25, 1947.

| | Duration |
|---|---|
| Immediate cause of death: Congestive heart failure | 2 hrs. |
| Due to: Arteriosclerotic heart disease | ? |
| Due to | |
| Other Conditions: Bronchopneumonia | 10 days |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward H. Jones, Jr. M. D.
Address U. M. H. Date signed 2-25-47

G43032

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH ✓937

G43032

Reg. Dist. No. .....

1. PLACE OF DEATH
~~County~~ ~~Balto Co~~ 3607 - 5th St
City or town Brooklyn Balto City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred: .....
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto
City or town Brooklyn
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3607 - 5th St
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME Hester P Bryant

3.(b) Social Security Number

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Widow |

6. Name of husband or wife .....
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Jan 5 - 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 1 | 19 | ..... hrs. ..... min. |

9. Birthplace Virginia (State, county, and state)
10. Usual occupation Retired
11. Industry or business .....
12. Name Tolan, Davis
13. Birthplace Virginia
14. Maiden name Myrtle Blaine
15. Birthplace Virginia
16. Informant Mrs E L Payne
Address 1349 Patapsco Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 27 - 47 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location .....
18. Funeral director Charles J Powell
Address 2417 Edmondson Ave
FEB 26 1947 Huntington Williams Baltimore
(Date rec'd by registrar) 19

### MEDICAL CERTIFICATION

20. DATE OF DEATH 2/24 19 47 at 6 70 p.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1 19 47 to 2-24 19 47
and that I last saw h.er alive on Feb 24 19 47
Immediate cause of death Chronic myocarditis
Acute Heart Block
DURATION one year
Due to .....
Due to .....
Other conditions .....
(Include pregnancy within 3 months of death)
Major findings of operations — Date of op. .....
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Jas. H Phillips M. D. or other
Address 1939 Edmondson Ave Date signed 2-25-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49033 — BALTIMORE CITY HEALTH DEPARTMENT — Dorn 47c — Registered No. G49033

# CERTIFICATE OF DEATH

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert St
(c) Hospital or institution: Mercy Hosp 3E
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State West Va. (b) County
(c) City or town Martinsburg (If outside city or town limits, write RURAL and give town)
(d) Street No. 225 S Spring St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

**3 (a) FULL NAME** Mr. Martin Dorn

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | married |

6 (b) Name of husband or wife Grace Dorn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 13, 1907

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 39 | 5 | 12 | 12 hr. 45 min. |

9. Birthplace West Va (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Ed. Wm. Dorn
13. Birthplace West Va.

MOTHER
14. Maiden Name Carrie Branter
15. Birthplace West Va

16 (a) Informant
(b) Address Hyde

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 1-1947 (month) (day) (year)
(c) Cemetery or crematory Rosedale Cemetery
Location Martinsburg, West Virginia

18 (a) Funeral director H. W. Pearsall Son
(b) Address 805 N. Calvert St.

19 (a) (Date rec'd by registrar) (b) Huntington Williamson

VS 150 Via: Headle.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26 1947, at 12:20 Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1947 to Feb 26 1947. and that I last saw him alive on Feb 26 1947.

Immediate cause of death Tension Pneumothorax - Empyema of Rt lung cavity — Duration —
Due to Following Pneumonectomy for —
Due to Carcinoma - Bronchogenic —
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: Pneumonectomy Ca of lung
of autopsy Obtained

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Laurence J. Hoff M.D.
Address Mercy Hosp. Date signed 2-28-47

X

G49031

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

121a

G49034

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 141 N. Linwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 141 N. Linwood Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary L. Chirigo

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Henry Chirigo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8. 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 4 | 15 | hr. min. |

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Home Keeper
11. Industry or business

FATHER
12. Name Angelo Bacigalupo
13. Birthplace Italy

MOTHER
14. Maiden Name Mary Costa
15. Birthplace Italy

16 (a) Informant Margaret Britta
(b) Address 141 N. Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 27. 47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Frederick Road

18 (a) Funeral director Geo L. Berger Jr
(b) Address 1512 Fallsway St

19 (a) (Date rec'd by registrar) (b) Irvington Williams M.D. Registrar

FEB 26 1947

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb. 23 1947 at 9 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1 1946 to Feb. 23 1947 and that I last saw her alive on Feb 23 1947.

Immediate cause of death: Cardio vascular nephritis — Duration: 2 yrs.
Due to: Arteriosclerosis and age
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul L. Valentine M.D.
Address 732 N. Broadway Date signed 2/25/47

D.C. Dif 2100

G43035

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

G43035
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Caton Aves.
(c) Hospital or institution: St. Agnes Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 29
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 Haverhill Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Moran

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-25-47

8. AGE: Years | Months | Days | If less than one day: hr. 23 min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Wm. D. Moran
13. Birthplace Md.

MOTHER
14. Maiden Name Teresa Price
15. Birthplace Md.

16 (a) Informant Mrs. Thos D Moran
(b) Address 1117 Haverhill Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/27/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md

18 (a) Funeral director Geo L Boyer Jr
(b) Address 1512 Hollins St

19 (a) 2/26/47 (Date received by registrar) (b) Clayton Williams (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-25 1947, at 2.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-25 1947 to 2-25 1947, and that I last saw h. alive on 2-25 1947.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to | |
| Due to | |
| Other Conditions Prematurity monstrosity | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert J. Sinclair M.D.
Address St. Agnes Hosp. Date signed 2/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G49036

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓61

G49036 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Rayner Ave. & Dukeland St.
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 7 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1613 E. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

2 (a) FULL NAME Mrs. Lillian M. Wagner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Robt Wagner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1886

8. AGE: Years 61 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name HENRY DETERS
13. Birthplace ?

MOTHER
14. Maiden Name MARY ANN BUSCH.
15. Birthplace ?

16 (a) Informant ADOLPH. WAGNER
(b) Address 305 E CROSS ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof FEB-26-47 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location A.A.Co.

18 (a) Funeral director Bernard C. Harlow
(b) Address 121 E West St

2-27-1947 (Date filed by Registrar) Wm. [illegible] Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 25, 1947, at 2:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20, 1947 to Feb 25 1947 and that I last saw h[illegible] alive on Feb 25, 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardio - respiratory failure | |
| Due to Subarachnoid hemorrhage, Spontaneous | |
| Due to | |
| Other Conditions Diabetes mellitus, Cataract, left eye (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy Same as above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leon Toby M.D.
Address West Balto. Gen. Hosp. Date signed 2/25/47

83a

VS 150

G49037

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 163H

Registered No. G49037

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 139yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1304 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** (CLEVELAND R. FLETCHER) ROBERT C. FLETCHER

3 (b) If veteran, name war

3 (c) Social Security Account No.

**MEDICAL CERTIFICATION** 42

**20. DATE OF DEATH** February 25 1947, at 12 P M

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Loretta Fletcher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1919

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 27 26 | 8 | 15 | hr. min. |

9. Birthplace Va (Town, county, and state)

10. Usual Occupation

11. Industry or business Eastern Stainless Steel

FATHER 12. Name Thorton Fletcher
13. Birthplace Va

MOTHER 14. Maiden Name Ellena Peaches
15. Birthplace Va

16 (a) Informant Loretta Fletcher
(b) Address 1365 N. Broadway

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb-28/47 (month) (day) (year)
(c) Cemetery or crematory Locust Grove Cemetery
Location Va

18 (a) Funeral director Philip Stewart Sons
(b) Address 2024 Pleasant St

19 FEB 27 1947 (Date rec'd by registrar) Huntington Williamsport

**21.** I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

**IMMEDIATE CAUSE OF DEATH** Asphyxiation

Due to Illuminating gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-25-47 at 11:45 A. M.
(b) Where did injury occur? 1304 N. Broadway
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury Unlit burners on gas range, oven & heater

23. Signature Howard J. Haggerty, M.D. Medical Examiner.
Date signed 2-25-47

VS 191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

649038

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1623

Registered No. 63038

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 925 Pennsylvania Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-1
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 925 Pennsylvania Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Aaron Louis Frank

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Widower |

6 (b) Name of husband or wife Late Minnie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | | | hr. min. |

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business None

FATHER
12. Name Benjamin Frank
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Paul Frank
(b) Address 925 Pennsylvania Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 27/47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cemet.
Location Hamilton Ave.

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1124-26 W. North Ave.

19 (a) (Date received by registrar) Registrar

FEB 27 1947

VS 150

Huntington Williams, Md

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26 1947, at 3P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1946 to Feb. 26 1947 and that I last saw him alive on Feb. 26 1947

| Immediate cause of death | Duration |
|---|---|
| Uremia | Twk. |
| Due to Senility | 5 yrs. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Levinson, M.D.
Address 1601 N. Broadway Date signed 2/26/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C49039

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

Registered No. C49039

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4122 Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4122 Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ethel Fox

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-03-3200

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 47 | Months | Days | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Book keeper

11. Industry or business

FATHER 12. Name Bender

FATHER 13. Birthplace New York

MOTHER 14. Maiden Name Ida

MOTHER 15. Birthplace Russia

16 (a) Informant father

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-27-47 (month) (day) (year)

(c) Cemetery or crematory Arlington

Location Rogers Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E. Balto St

19 (a) (Date rec'd by local reg.) (b) Registrar

VS 750

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/26/47 19 , at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1946 to 2-26 1947, and that I last saw h.e.r alive on Feb 24 1947.

Immediate cause of death Coronary Thrombosis — Duration 1½ hours

Due to

Due to

Other Conditions Hypertension — 4 years +

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: /

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ada Bernstein

Address 109 N Calvert St Date signed 2/26/47 M. D.

Balto X

G49040

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G49040

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1807 MORELAND AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-3
(e) Length of stay in Baltimore (yrs., mos., or days) 35 YRS

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 MORELAND AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA FLETCHER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife HARRY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 56 Months Days If less than one day hr. min.

9. Birthplace ROUMANIA (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER
12. Name LEON BROWN
13. Birthplace ROUMANIA

MOTHER
14. Maiden Name SARAH
15. Birthplace ROUMANIA

16 (a) Informant HUSBAND
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2-27-47 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location PHIL RD & HAMILTON AVE

18 (a) Funeral director JACK LEWIS INC
(b) Address 2100 EUTAW PLACE

19 (a) FEB 27 1947 (Date received by registrar) (b) Huntington for Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 26 1947, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from FEB. 24 1947 to FEB 26 1947 and that I last saw her alive on FEB. 26 1947

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | |
| Due to Hypertension | |
| Cardiac Vascular Disease | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. E. Needle

Address 1314 - 00. North Ave Date signed 2/26/47 M. D.

X

C49011

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

Registered No. C49011

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4009 Norfolk Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4009 Norfolk Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Israel Rudoff

3 (b) If veteran, name war —
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Sheet Metal Worker
11. Industry or business

FATHER
12. Name Rubin
13. Birthplace Russia

MOTHER
14. Maiden Name Trudy
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (b) Date thereof 2-27-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bnai Israel
Location Southern Ave

18 (a) Funeral director Sam Levine Inc
(b) Address 1439 E. Balto St

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/26/47 19 , at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to Feb 26 1947 and that I last saw him alive on Feb 26 1947

Immediate cause of death Coronary thrombosis — Duration 2 years
Due to Hypertension
Due to Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sol L. Smith
Address 1223 E North Date signed 2/26/47 M.D.

VS-150

FEB 27 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G45012

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

157E

Registered No. G45012

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Va. (b) County
(c) City or town Sandston (If outside city or town limits, write RURAL and give town)
(d) Street No. 7 W. Sedgwick St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Robert Lee Williams Jr

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-30-35

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 11 | 4 | 27 | hr. min. |

9. Birthplace Va (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Robert Lee Williams
13. Birthplace Va

MOTHER
14. Maiden Name Mollie Baughan
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 27 1947 (month) (day) (year)
(c) Cemetery or crematory
Location Richmond Va

18 (a) Funeral director Mrs. John W. Teufel & Son
(b) Address 5311 Edmondson Ave

19 (a) (Date received by registrar) (b) Registrar

FEB 27 1947 Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 26 1947 at 2:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24 1947 to Feb 26 1947 and that I last saw him alive on Feb 26 1947

| Immediate cause of death | Duration |
|---|---|
| Post operative Haemorrhage | |
| Due to Tetralogy of Fallot | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation 2/26/47
Major findings of operation: Pulmonic stenosis
of autopsy: Tetralogy of Fallot

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry F. Bahnson M.D.
Address Johns Hopkins Hospital Date signed 2/27/47

X

G49043

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48 B

Registered No. G49043

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lexington Street
(c) Hospital or institution: Fayette Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 W. Lexington Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Mary T. Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | Married |

6 (b) Name of husband or wife William C. Clark
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 8 | 28 | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henrich Scholle
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mollie Ebbley
15. Birthplace Maryland

16 (a) Informant Mrs. Sadie Schrink
(b) Address 1635 Cliftview Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 27 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1947, at 10 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 11 1946, to Feb 25 1947, and that I last saw h[illegible] alive on Feb 25 1947

Immediate cause of death: Carcinoma of Uterus — Duration: 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stephen L. Solomon, M.D.
Address 129 W. Broadway Date signed 2/28/47

G48014

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

Registered No. G48014

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 263 N 9th
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 263 N 9th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lewis H Slade

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Sarah E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 22 1864

8. AGE: Years 82 | Months 10 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Carroll Co Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Lewis H Slade Sr.
13. Birthplace Md

MOTHER 14. Maiden Name Sarah E Pocock
15. Birthplace Md

16 (a) Informant Mrs Chorley F Smith
(b) Address 263 N. 9th St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3/1/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Co Md

18 (a) Funeral director Wilson & Son
(b) Address 1217 Cont Ave

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

VS 150

FEB 27 1948

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 26 1947, at 4 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21, 1947 to Feb 26, 1947 and that I last saw him alive on Feb 24, 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral apoplexy | 5 days |
| Due to Arteriosclerosis | ? |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice E. Abrams M D
Address 5200 W. Northern Date signed 3/2/1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19015

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 112

Registered No. G19015

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1615 Joplin Street
(c) Hospital or institution: 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Joplin Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Irene Most (IRENE MOST)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 215-05-3778

4. Sex: f

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Vernon J. Most

6 (c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): Dec. 23, 1908

8. AGE: Years 38 | Months 2 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Saleslady

11. Industry or business: May Co.

FATHER
12. Name: George Leyshon
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Mary Henlein
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mr. Vernon J. Most
(b) Address: 1615 Joplin Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/47 (month) (day) (year)
(c) Cemetery or crematory: OakLawn Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) (b)

Filed FEB 27 1947 Thurlington Registrar, Md.

VS 181

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/25/47 19 , at 5:45 p.m.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Status Asthmaticus

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John L. Watts, M.D. Medical Examiner.
Date signed 2/26/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49016

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

Registered No. G49016

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St
(c) Hospital or institution: St Joseph's Hospital Baltimore Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) ~~7 days~~ 30 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3223 Abell Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mr Byron Matthai (BYRON MILLER MATTHAI)

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 218-10-5872

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lenise M. Matthai
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) April 3, 1897

8. AGE: Years 49 | Months 10 | Days 23 | If less than one day ....hr. ....min.

9. Birthplace Chicago, Ill (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business May Oil Burner Co.

FATHER 12. Name Harry E. Matthai
13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden Name Rose Mack
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Lenise M. Matthai
(b) Address 3223 Abell Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) ....(Date rec'd by registrar) (b) .... Registrar

FEB 27 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 26th 1947 at 3:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/19 1947 to 2/26 1947. and that I last saw him alive on 2/26 1947

| Immediate cause of death | Duration |
|---|---|
| Cardio-Respiratory failure | |
| Due to Cerebral Hemorrhage left side | |
| Due to | |
| Other Conditions Hypertension essential | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ....at ....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Lemonski M. D.
Address 4 Jo. Hopkins Date signed 2/26/47

G45017 ✓ G45017

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE AND JOHN STS
(c) Hospital or institution:
HOSPITAL FOR THE WOMEN OF MARYLAND
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 27-14

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MARYLAND (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5606 BLAND AVE
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

**3 (a) FULL NAME** Mary (Marie) CASPER MILES

3 (b) If veteran, name war —

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | M |

6 (b) Name of husband or wife ALVIN R. MILES, Sr.
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) APRIL 11, 1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 10 | 14 | ____ hr. ____ min. |

9. Birthplace Abingdon, VIRGINIA (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business HOME

FATHER
12. Name CASPER SUMMERFIELD
13. Birthplace VA Germany

MOTHER
14. Maiden Name MARGARET DASA
15. Birthplace VA

16 (a) Informant MR ALVIN MILES Sr.
(b) Address 5606 BLAND AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 2 7 1947 (Date received by Registrar) (b) Huntington Williams, M.D. (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 25 FEB. 1947, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 18 FEB 1947, to 25 FEB 1947, and that I last saw her alive on 25 FEB 1947.

| | Duration |
|---|---|
| Immediate cause of death CARDIO RESPIRATORY FAILURE | |
| Due to CEREBRO VASCULAR ACCIDENT (HEMORRHAGE) | 4 DAYS |
| Due to HYPERTERTENSIVE CARDIO VASCULAR DISEASE | 15 YRS |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James B Cary Jr. M. D.
Address Women's Hospital Date signed 2-25-47

VS 8

D

X

G43018 BALTIMORE CITY HEALTH DEPARTMENT G43018

# CERTIFICATE OF DEATH 33 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2114 N. Calvert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2114 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Elizabeth Binkley Price

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Edwin Price

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17 1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 8 | 8 | hr. min. |

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Chas H. Binkley
13. Birthplace Ohio

MOTHER
14. Maiden Name Georgiana Holland
15. Birthplace Indiana

16 (a) Informant Louis C. Binkley (Nephew)
(b) Address 4420 Ruckle St. Indianapolis, Ind.

17 (a) Burial (b) Date thereof 2/27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) FEB 27 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1947, to Feb 25 1947 and that I last saw h[illegible] alive on Feb 24 1947.

Immediate cause of death: Influenza — Duration: 3 days
Due to: Senility
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Pearce
Address 205 Charles Date signed 2 Mar 1947
M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 92 B

G43019 G43019 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts., Balto. 18
(c) Hospital or institution:
Union Memorial Hospital 26-11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 49 YRS.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County —
(c) City or town BALTIMORE 24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 930 So. EAST AVE (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME JOSEPH SCHULTZ (Kantorski)

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife MRS. STELLA SCHULTZ (Kantorski)
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) FEB. 2, 1898

8. AGE: Years 49 | Months 0 | Days 23 | If less than one day — hr. — min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation SALES ROADMAN.
11. Industry or business

FATHER
12. Name JOHN SCHULTZ (Kantorski)
13. Birthplace GERMANY.

MOTHER
14. Maiden Name MARY ?
15. Birthplace GERMANY.

16 (a) Informant Hosp. records.
(b) Address U.M.H. 33rd & Calvert St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-1-47 (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS
Location MT. CARMEL ROAD.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 (a) — (Date rec'd by Registrar) (b) — Registrar

FEB 27 1941

VS 150

Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 25 1947, at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from FEB. 20 1947, to FEB. 25 1947, and that I last saw him alive on FEB. 25 1947.

Immediate cause of death PULMONARY EMBOLISM — Duration 5 MIN.
Due to RHEUMATIC HEART DISEASE — Duration ?
Due to — Duration —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy AORTIC STENOSIS & MITRAL INSUFFICIENCY

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Edward H. Mayer Jr. M. D.
Address U.M.H. Date signed 2-25-47

X

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G43050 ✓ 51 B

Registered No. G43050

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 74 Years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3707 Greenmount Avenue
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

**3 (a) FULL NAME** Alfred R. Rickes

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife Carrie M. Wagner
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr) Dec. 27, 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 1 | 19 29 | — hr. — min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Druggist
11. Industry or business --------

FATHER
12. Name John Rickes, Jr.
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Sallie A. Hollingsworth
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Carrie M. Rickes
(b) Address 3707 Greenmount Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. W. Meeks and Son
(b) Address 805 N. Calvert Street

19 (a) ---- (Date rec'd by registrar) (b) ---- Registrar

VS FEB 27 1947 Huntington

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 26 Feb 1947, at 12m Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Feb 1947 to 26 Feb 1947, and that I last saw h[illegible] alive on 26 Feb 1947.

Immediate cause of death HYPERTENSIVE Cardio Vascular Renal Disease C DECOMPENSATION Grade IV — Duration
Due to C UREMIA & ACIDOSIS
C BLADDER CALCULI
Due to C PROBABLE CA OF PROSTATE

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 17 FEB 47
Major findings of operation: BLADDER CALCULI Benign PROSTATIC HYPERTROPHY C CARCINOMA
of autopsy: NONE DONE

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E. Bauer M. D.
Address Univ. Hospital Date signed 26 Feb 47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19051

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

97

G19051 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 419 S Ellwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 419 S. Ellwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Gottschalk

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14 1869

8. AGE: Years 78 | Months - | Days 12 | If less than one day hr. min.

9. Birthplace Wis.
(Town, county, and state)

10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Francis X. Gottschalk
13. Birthplace Germany

MOTHER
14. Maiden Name Anna C. Kriegstein
15. Birthplace Germany

16 (a) Informant Francis X Gottschalk
(b) Address 5205 Eugene Ave.

17 (a) Burial (b) Date thereof 3 1 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Beloit Rd.

18 (a) Funeral director Mount Olivet Cemetery
(b) Address 32 S. Conkling St.

19 2-27 1947 Lington Williams, Registrar
(Date) (Signature of registrar)

VS 190

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 26 1947 at 2:A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 1946 to Feb 26 1947, and that I last saw h[illegible] alive on Feb. 25 1947

| Immediate cause of death | Duration |
|---|---|
| Acute Pancreatic Edema | |
| Due to Hypertension | |
| Arteriosclerosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. A. Fleming M. D.
Address 3563 Dale Ave. Date signed 2-27-47

X

G49052

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G49052 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 17
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 932 Little Pine St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Monroe Hackney

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-8153

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | |

6 (b) Name of husband or wife Ellen Hackney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | | | hr. min. |

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Nick Hackney
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown.

16 (a) Informant Ellen Hackney
(b) Address 932 N. Pine St

17 (a) Burial (b) Date thereof 3/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location West Port. Balto

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 922 N. Mount St. Balto.

19 (a) 3-7-1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 181

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 2/24 19 47 at 6 P.M.

**21.** I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic P.V. disease

Due to

Other Conditions Pneumonia of Lung
Lingers at pt. hand
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. L. Sulkowski M.D.
Medical Examiner.
Date signed 2/24/47

PRESS—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49053

BALTIMORE CITY HEALTH DEPARTMENT ✓

# CERTIFICATE OF DEATH 56E

G49053 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood + Greene St.
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 - 2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1039 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** David Lansdowne.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race col. | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Lucy.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1891

8. AGE: Years 55 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Jamaica B.W. Indies (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER 12. Name David A Lansdowne

13. Birthplace Jamaica, B.W. Indies

MOTHER 14. Maiden Name Emile

15. Birthplace Jamaica B.W. Indies

16 (a) Informant Lucy Lansdowne

(b) Address 1039 W Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 27, 1947 (Month) (Day) (Year)

(c) Cemetery or crematory Arbutus Mem.

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St

19 (a) Clayton Williams (Date rec'd by registrar) Registrar

FEB 27 1947 VS 165

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 1947, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb-4 1947 to Feb 23 1947 and that I last saw him alive on Feb. 22 1947

Immediate cause of death Hodgkin disease? Boeck's sarcoid?

Due to Pt. had marked

Due to Lymphadenopathy.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

Lymphadenopathy

of autopsy: full report not completed

Duration

PHYSICIAN

Underline the cause to which death should be charged, satisfactorily.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Gerald A. Martin M. D.

Address University Hospital Date signed 2-23-47

X

G49054

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48 B

Registered No. G49054

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1520 E. Eagan St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 E Eagan St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Clara Dell Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 20, 1908

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 39 | 1 | 4 | hr. min. |

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Richard Emgins
13. Birthplace Va.

MOTHER
14. Maiden Name Fannie Williams
15. Birthplace Va.

16 (a) Informant Eddie Thomas Smith
(b) Address 234 Kalmia Court Emmanuel

17 (a) Burial (b) Date thereof 2/27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn Md

18 (a) Funeral director Thos A Wilson
(b) Address 1000 Blandly ave

Date of registration 1947 (b) Signature of registrar Thos Williams M.D.

2/24/47 MEDICAL CERTIFICATION 11:45 AM

20. DATE OF DEATH 2-24 1947 at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-18 1947 to 2-24 1947.
and that I last saw h alive on 2-24 1947

Immediate cause of death Cardio-Renal Disease — Duration 2 wks

Due to Carcinoma of Uterus — 3 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. LeRoy Berry M. D.
Address 1420 E. Chase Date signed 2-26-47

VS 150

X

G49055

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 124a

Registered No. G49055

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address Fayette & Calhoun Sts

(c) Hospital or institution: Franklin Square Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 hrs

(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. ~~Fayette & Calhoun Sts~~ 1519 W. Baltimore St (Residence)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

**3 (a) FULL NAME** Anna May Nash

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex Fem

5. Color or race White

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/25/21

8. AGE: Years 26 | Months - | Days - | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name William Nash

13. Birthplace Balto, Co

MOTHER 14. Maiden Name Catherine Ruby

15. Birthplace Balto Co.

16 (a) Informant Mrs Catherine Nash

(b) Address 1519 W Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/47 (month) (day) (year)

(c) Cemetery or crematory London Park Cem

Location Frederick Rd

18 (a) Funeral director John J. Gowan & Son

(b) Address 901-03 Hollins St

19 (a) (Date rec'd by Registrar) FEB 27 1947 Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb. 25 1947, at 6:40 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2/24 1947 to 2/25 1947 and that I last saw h[illegible] alive on 2/25 1947.

| Immediate cause of death | Duration |
|---|---|
| 1. Pneumonia | |
| Due to Laennec's Cirrhosis of Liver | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Stanley B. Klyanowe, M.D.

Address Franklin Sq. Hosp. Date signed 2/28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G49056

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G49056

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 105 So Calhoun St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 3
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 105 So Calhoun St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia M. Eyler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex female 5. Color or race white

6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Emory L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2 1876

8. AGE: Years 70 | Months 2 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace Fredk Co Md (Town, county, and state)

10. Usual Occupation House work

11. Industry or business at home

FATHER 12. Name Jesse Davis

13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth Crawford

15. Birthplace Md

16 (a) Informant Mr Emory L Eyler

(b) Address 105 So. Calhoun St

17 (a) buried (Burial, cremation, or removal) (b) Date thereof 3/1/47 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet Cem

Location Frederick Md

18 (a) Funeral director John C Carson Sons

(b) Address 901-03 Hollins St.

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

FEB 27 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/26/1947 at 7-45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 1944 to Feb 26 1947, and that I last saw h[illegible] alive on Feb 26 1947.

Immediate cause of death Cerebral Haemorrhage (Right) — Duration 2/25/47

Due to Hypertensive Cardio-Vascular Disease. — ?

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carl P Rostkey

Address 1316 W Lombard St Date signed 2/27/47 (M. D.)

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G43057

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 97

Registered No. 64307

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 761 N. Mulberry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 - 2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 761 N. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife John Bailey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1882

8. AGE: Years 64 65 | Months 6 | Days 23 | If less than one day hr. min.

9. Birthplace Onancock, Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Mary Rice

15. Birthplace Virginia

16 (a) Informant Robert J. Bailey

(b) Address 761 N. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 27 1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Jas. Young, N. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 27 1947

V S 180

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-24-1947, at 8 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-15-1947, to 2-24-1947, and that I last saw her alive on 2-23-1947.

Immediate cause of death Arteriosclerosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. D. Bando M. D.
Address 2445 W. Hill Ave. Date signed 2-27-47

X

AB-105480 G48058

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 469

Registered No. G48058

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 15-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6mos-& 18days
(e) Length of stay in Baltimore (yrs., mos., or days) 10yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1566 N. Fremont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Ethel Gladden

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | Separated |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9- 1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | 7 | 14 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph T. Gladden
13. Birthplace Maryland

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 1, 1947 (Months) (day) (year)
(c) Cemetery or crematory St. Peters
Location Baltimore, Md.

18 (a) Funeral director Geo. Lavoye H. Holland
(b) Address 1631 Druid Hill Ave

19 (a) FEB 27 1947 (Date rec'd by registrar) (b) Registrar's No. 8

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23- 1947, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-5- 1946, to 2-23- 1947, and that I last saw h[illegible] alive on 2-23- 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure | |
| Due to general debility | |
| Due to Carcinoma of the pancreas with metastases | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Ca Pancreas with metastases

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin C. Evans M. D.
Address Balto. City Hosp. Date signed 2-26-47

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5096 G49059

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 15

Registered No. G49059

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 - 3
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 552 Baker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Esther b Richardson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-17-1903

8. AGE: Years 43 | Months 7 | Days 8 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Home - wife

11. Industry or business

FATHER 12. Name Samuel Crawford

13. Birthplace Md.

MOTHER 14. Maiden Name Gertrude Dennis

15. Birthplace Md

16 (a) Informant Frank R. Richardson

(b) Address 552 Baker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 1, 1947 (month) (day) (year)

(c) Cemetery or crematory Robert Mem. Park

Location Baltimore Co. Md.

18 (a) Funeral director Wm. Law A. Holland

(b) Address 1601 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 1947 at 2.10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 4 1947 to Feb. 25 1947, and that I last saw her alive on Feb. 25 1947

Immediate cause of death Peritonitis — Duration: Not Known

Due to Tuberculosis

Due to

Other Conditions Diabetes Mellitus — Duration: 1 yr (?)

(Include pregnancy within 3 months of death)

Date of operation 2/20/47

Major findings of operation: Tuberculous peritonitis

of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address Johns Hopkins Hosp Date signed 2/25/47

VS 150 FEB 27 1947 Huntington Williams, M.D.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 43060

43060 — 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2117 Denison Street
(c) Hospital or institution: Crawford Retreat 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3610 Hayward Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Orion E. Berry

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Mary Virginia Berry
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 13-1858
8. AGE: Years 88 | Months 3 | Days 13 | If less than one day hr. min.
9. Birthplace Maryland (State, county, and city)
10. Usual Occupation Clerk - Chesapeake Steamship Co
11. Industry or business Retired 15 years

FATHER
12. Name George Berry
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Barnhart
15. Birthplace Maryland

16 (a) Informant Norman L. Berry
(b) Address 3610 Hayward Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 28-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Mays (Hampden)
Location Baltimore, Maryland

18 (a) Funeral director Burgiel Funeral Home
(b) Address 3631 Falls Road

19 (c) FEB 27 1947 (Date received by registrar) Huntington Hillman Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 25 1947, at 3:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 21 1947 to Feb 25 1947 and that I last saw h[illegible] alive on Feb 25 1947

Immediate cause of death: Bronchopneumonia — Duration: 1 Day
Due to: Fracture of Left Hip, Fell off Ice, Hayward — Collapsed
Due to: Senility
Other Conditions: —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide — Accident
(b) Date of occurrence Feb. 21-1947
(c) Where did injury occur? Hayward Maryland (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? public (specify type of place) While at work? no
(e) Means of injury Fell on ice

23. Signature Charles J. Weeks
Address 5276 Park Heights Ave Date signed Feb 26 47

Howard J. Andrews, M. D.

G42061

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G42061

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3442 Chestnut Avenue
(c) Hospital or institution: 13-6
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days) 75 years.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3442 Chestnut Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Arthur Thompson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Elmira C. Thompson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 23-1860
8. AGE: Years 86 Months 11 Days 2 If less than one day hr. min
9. Birthplace Montgomery Co. Maryland (town, county, and state)
10. Usual Occupation Policeman
11. Industry or business Retired 17 years

FATHER
12. Name Samuel Thompson
13. Birthplace Maryland

MOTHER
14. Maiden Name Louise —
15. Birthplace Maryland

16 (a) Informant Mrs. Elmira C. Thompson
(b) Address 3442 Chestnut Avenue
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 28-1947 (month) (day) (year)
(c) Cemetery or crematory St. Mary's (Cemetery)
Location Baltimore, Maryland
18 (a) Funeral director Durgee Funeral Home
(b) Address 3621 Falls Road
19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 FEB 27 1947 Waiting for Physician's

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb. 25- 1947, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 13 1946 to Feb 25 1947, and that I last saw h alive on Feb 25 1947.

| Immediate cause of death | Duration |
|---|---|
| Myocardial muffering. | |
| Due to Arteriosclerotic Cardiac disease | |
| Due to | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature L. W. Smith M. D.
Address 3429 Chestnut St. Date signed 2/26/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

509806. G49062

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH X 46H

Registered No. G49062

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Fla. (b) County
(c) City or town Sarasota
(If outside city or town limits, write RURAL and give town)
(d) Street No. 650 S Palm Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Raymond R. Wasson.

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male. | White | single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-29-14

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 32. | 3 | 28 | hr. min. |

9. Birthplace Ill.
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Otto Wasson
13. Birthplace Ill.

MOTHER
14. Maiden Name Anna Steiger
15. Birthplace Ill

16 (a) Informant Rhonda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial, cremation, or removal (b) Date thereof 2/27/47 (month) (day) (year)
(c) Cemetery or crematory Chicago
Location Chicago, Ill

18 (a) Funeral director Milton J. Lee
(b) Address 1317 N. Eutaw St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS FEB 27 1947

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH Feb. 27 1947, at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 11 1947 to Feb. 27 1947, and that I last saw him alive on Feb. 27 1947.

| Immediate cause of death | Duration |
|---|---|
| UREMIA | |
| Due to OCCLUSION RENAL ARTERIES | |
| Due to RETROPERITONEAL TUMOR | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation 2-21-47
Major findings of operation: Large retroperitoneal mass
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. C. Sanford
Address Johns Hopkins Hospital
Feb 27, 1947

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1513 North Bond G39063

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46E

Registered No. G39063

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1510 N. Port Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 N. Port Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Catherine A. Bottomley

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | white | widowed |

6 (b) Name of husband or wife Charles S.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 8 | 25 26 | hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John H. Franz
13. Birthplace ?

MOTHER
14. Maiden Name Mary M. ?
15. Birthplace ?

16 (a) Informant Catherine Maydwell
(b) Address 3626 Elmly Avenue

17 (a) Burial (b) Date thereof 3/1/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 26 1947, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24 1947, to Feb 26 1947, and that I last saw h[illegible] alive on Feb 24 1947.

Immediate cause of death Pneumonia, Lobar

Duration: after 14 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 1513 N. Milton Ave Date signed Feb 27 47

VS 190

FEB 27 1947

X

G49064

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G49064 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 605 Claymont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 6
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 605 Claymont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** May ZAK

3 (b) If veteran, name war: 10
3 (c) Social Security Account No.: nine

| 4. Sex | 5. Color or race | 6 (a) ~~Single, married~~, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife: Frank J Zak
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26th 1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | 9 | 0 | hr. min. |

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name (Unknown) Jackson
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Millington B. Holter
(b) Address 2632 Edmondson Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md
18 (a) Funeral director William Cook Sons
(b) Address 1217 St. Paul St.
19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 26th 1947, at 3.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24 1947 to Feb 26 1947 and that I last saw h[illegible] alive on Feb 26 1947.

Immediate cause of death Coronary thrombosis
arteriosclerotic heart disease
Duration one day
Due to
Due to
Other Conditions Acute Enteritis infection 3 days
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury W. Michel

23. Signature
Address 2901 Edmondson Ave Date signed Feb 26 47 M. D.

VS 150

FEB 27 1947

G49065 BALTIMORE CITY HEALTH DEPARTMENT G49065

# CERTIFICATE OF DEATH 47c

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital 3-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 S. Carolina St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Norman Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-5986

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 50 | | | hr. min. |

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

| | |
|---|---|
| FATHER | 12. Name |
| | 13. Birthplace Unk |
| MOTHER | 14. Maiden Name |
| | 15. Birthplace |

16 (a) Informant Sam Seamons
(b) Address 1400 E. Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Balto Co, Md.

18 (a) Funeral director Rafferty Williams
(b) Address 1575 McElderry St

19 (a) (Date rec'd by registrar) (b) Registrar
FEB 27 1947 Livingston Hillsville, Md

vs

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1947 at 3:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchogenic Carcinoma

Due to [redacted]

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William L. Fetterolf M.D.
Medical Examiner.
Date signed 24 Feb 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46 D

Registered No. 64066

64066

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1602 Rosedale St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 Rosedale St., (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Christina Griffin

3 (b) If veteran, name war ----
3 (c) Social Security Account No. 212-03-8827

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife -----
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 2 | 0 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Sales Lady
11. Industry or business Stewart & Co.

FATHER
12. Name Edward J. Griffin.
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary McEnaney
15. Birthplace Ireland

16 (a) Informant Mrs. Margaret Tignall
(b) Address 1602 Rosedale St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director L. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) (Signature of registrar) (b) Registrar

FEB 27 1947 Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 25, 1947, at 1.10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/11 1946 to 2/25 1947, and that I last saw her alive on 2/24 1947

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of Rectum | 3 yrs ? |
| Due to Generalized Metastasis of stomach and liver | ? |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation Dec 2d 1946

Major findings of operation: Inoperable Carcinoma of Rectum with metastasis

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Daniel J. Shannon M. D.

Address 835 Cutpsis Falls Rd Date signed 2/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49067

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G49067

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1517 Division St.
(c) Hospital or institution: Provident Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7days
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore 3 14
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2330 Madison Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Maggie Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov-12-1894

8. AGE: Years 52 | Months 3 | Days 12 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Leroy Gantt
13. Birthplace P.G. Co. Md

MOTHER 14. Maiden Name Annie Deubut
15. Birthplace P.G. Co. Md

16 (a) Informant Harry Nilson
(b) Address 2330 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-47 (month) (day) (year)
(c) Cemetery or Crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Kemp
(b) Address 578 W. Biddle St.

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 27 1947 Huntington Williams, M.D.

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb 24 1947, at 8 1/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1947, to Feb 24 1947, and that I last saw h at alive on Feb 24 1947

| Immediate cause of death | Duration |
|---|---|
| Congestive Heart Failure | |
| Due to Arteriosclerotic Heart Disease | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. Mussenden M. D.
Address 2309 Druid Hill Ave Date signed 2-26-47

MUSSENDEN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G49068 Registered No. G49068

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 26 N Ellwood, Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 26 N Ellwood, Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARY C. VOGT

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Widowed |

6 (b) Name of husband or wife Henry J Vogt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 13, 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 1 | 12 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name William T Lemon
13. Birthplace Unknown

MOTHER
14. Maiden Name Lena Demnech
15. Birthplace Unknown

16 (a) Informant Lillian Heath
(b) Address 2712 Inglewood, Ave.

17 (a) Burial (b) Date thereof 3 1 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis, Blvd.

18 (a) Funeral director Leidy & Zeiler Inc.
(b) Address 403 S. Wolfe St. Balto. Md.

19 (a) FEB 27 1947 (b)
(Date received by registrar) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1947, at 2:15 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from December 25 1946 to Feb 25 1947, and that I last saw her alive on Feb 25 1947.

| | Duration |
|---|---|
| Immediate cause of death: Acute pulmonary edema | 1 hr. |
| Due to: Acute left heart failure | |
| Due to: Hypertensive cardio-vascular disease | yrs. |
| Other Conditions: | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James K. Insley Jr. M. D.
Address 2936 E. Baltimore St. Date signed 2/27/47

Huntington Williams, M.D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G49089 / 108

Registered No. G49089

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State W. Va. (b) County
(c) City or town Martinsburg (If outside city or town limits, write RURAL and give town)
(d) Street No. 721 Winchester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Patricia Wroe.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-27-47

8. AGE: Years | Months: 1 | Days | If less than one day: hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Arthur Wroe.
13. Birthplace W. Va.

MOTHER
14. Maiden Name Katherine Miller.
15. Birthplace W. Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 28/47 (month) (day) (year)
(c) Cemetery or crematory, Location Martinsburg, W. Va.

18 (a) Funeral director John D. Whitehill & Son
(b) Address 1901 Eutaw Place

19 (a) (b) (To be filled in by registrar) Registrar

2-27-1947 Lucington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1947, at 3:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 26 1947 to Feb. 27 1947 and that I last saw h.er alive on Feb. 27 1947.

| Immediate cause of death | Duration |
|---|---|
| Pneumonia, Lobar RUL | |
| Tracheo-oes-Fistula | |
| Due to Malnutrition | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert Ehrmann M. D.
Address Johns Hopkins Hospital Date signed 2-27-47

X

G5070 Birth Certificate G-71649

TH. 108475

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

161a

G45070 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 Sterling St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Girl ( Davis ( Catherine

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 11th. 1947

8. AGE: Years | Months | Days | If less than one day: hr. 1 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward H. Davis Jr.
13. Birthplace Va.

MOTHER
14. Maiden Name Catherine Thompson
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records)

17 (a) (Burial, cremation, removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Cremated
Location

18 (a) Funeral director Balto. City Hosp.
(b) Address

19 (a) 1/15/47 (Date rec'd by registrar) (b) Huntington Williams M.D.

**MEDICAL CERTIFICATION** A.M

20. DATE OF DEATH Jan. 11th 1947, at 8.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 11th 1947, to Jan. 11 1947, and that I last saw her alive on Jan. 11th 1947.

| | Duration |
|---|---|
| Immediate cause of death: Congenital pulmonary atelectasis (bilateral) | 10 min |
| Due to: | |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: See above.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Blanc M. D.
Address Balto. City Hosp Date signed 2-19-47

VS 150

C49071 C49071

BALTIMORE CITY HEALTH DEPARTMENT

BH C64468 CERTIFICATE OF DEATH 182a

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5412 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Noel McLeod HOCKING

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 14 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 0 | 2 | 16 14 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Alfred E. Hocking Jr
13. Birthplace Balto, Md

MOTHER
14. Maiden Name Pamela Wollen
15. Birthplace Spalding, England

16 (a) Informant Alfred E. Hocking Jr
(b) Address 5412 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-47 (month) (day) (year)
(c) Cemetery or crematory Stone Chapel
Location Pikesville, Md

18 (a) Funeral director Lorenz Bivens
(b) Address 5005 Park Heights Ave

19 (a) (Date received by registrar) Huntington Williams (Registrar)

VS 131

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 25 1947, at 3:20 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Mechanical suffocation

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 27/18
(a) Date of injury 2-25-47 at 3P. M.
(b) Where did injury occur? 5412 Park Heights Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Suffocated by bedclothes

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 2/26/47

PRESS WRITE FIRMLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

X

G39072

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 750

G39072 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) All my life.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 318 Murdock Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs Nellie S. Haury

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No. | ? |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Single |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 1 | 22 | 3 hr. 45 min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name John W Haury
13. Birthplace Virginia

MOTHER
14. Maiden Name Caroline Arnold
15. Birthplace Virginia

16 (a) Informant Mrs Minnie F. Haury
(b) Address 318 Murdock Road

17 (a) Burial (b) Date thereof 3/3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) FEB 28 1947 (b) Huntington Williamsburg, W.Va.
(Date received by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27 1947; at 3:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-24 1947, to 2-27 1947, and that I last saw her alive on 2-26 1947.

| | Duration |
|---|---|
| Immediate cause of death: Bronchopneumonia | 4 wks |
| Due to: Arteriosclerosis | ? |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Not necessary

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Union Mem. Hosp. Date signed 2/27/47

VS 150

727

G49073

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

157E

Registered No. G49073

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Tenn (b) County
(c) City or town Oakridge (If outside city or town limits, write RURAL and give town)
(d) Street No. 104 West Malta Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Mary Kay Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | — |

6 (b) Name of husband or wife

6 (c) If alive, give age ~~46~~

7. Birth date of deceased (mo., day, yr.) 3-29-~~07~~

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| — | 10 | 28 | hr. min. |

9. Birthplace Oak Ridge, Tenn (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wm. J. Martin

Thornburg Va

MOTHER 14. Maiden Name Mary Hays

15. Birthplace Cave City Ky

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 2/28/47 (month) (day) (year)
(~~Burial, cremation~~ removal)

(c) Cemetery ~~or crematory~~ Cave City

Location Kentucky

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

FEB 28 1947 (b) Huntington Nelligan M.D.
(Date received by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 27, 1947, at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 25 1947 to Feb. 27 1947, and that I last saw h e alive on Feb. 27 19 47.

| Immediate cause of death | Duration |
|---|---|
| Due to Congested Heart Disease | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George S Palmer

Address Harriet Lane Home Date signed 2-27-47 M.D.

VS 150

X

G49074

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

46B

Registered No. G49074

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 day
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Harford
(c) City or town Elkridge (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William C. Hohman
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Sallie B. Hohman
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 5th 1869
8. AGE: Years 77 | Months 5 | Days 22 | If less than one day hr. min.
9. Birthplace Md. (a. a. Co.) (Town, county and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Christopher Hohman
13. Birthplace Hanover, Germany

MOTHER
14. Maiden Name Katherine E. (Unknown)
15. Birthplace Hanover, Germany

16 (a) Informant Mrs. Sallie Hohman
(b) Address Elkridge Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location a. a. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

FEB 28 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27 1947, at 3:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23, 1947 to Feb 27 1947, and that I last saw h[illegible] alive on Feb 27, 1947.

Immediate cause of death Cardio resp failure — Duration

Due to Arteriosclerotic C-V disease — Duration

Due to Nephrosclerosis — Duration

Other Conditions Hypertension, Ca stomach, Pneumothorax — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Erwin R. Jennings M. D.
Address Univ. Hosp. Date signed 2/27/47

VS 150

G19075

Temp. Residence: 108 N. Eutaw St.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G19075 Registered No. 163 B

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Pa. (b) County
(c) City or town Johnstown (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** PAUL GROSCHI

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 40 | | | hr. min. |

9. Birthplace Johnstown Pa (Town, county, and state)

10. Usual Occupation

11. Industry or business Not Employed

FATHER
12. Name Jacob Grosch
13. Birthplace Pa

MOTHER
14. Maiden Name Agnes Rees
15. Birthplace Pa

16 (a) Informant Jacob Grosch
(b) Address 210 Pine St. Johnstown Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 3, 1947 (month) (day) (year)
(c) Cemetery or crematory St Joseph's
Location Johnstown Pa

18 (a) Funeral director Harry H. Witzke
(b) Address 401 Edmondson Ave

19 (a) FEB 28 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 26, 1947 at 2 A.M. 55

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Barbiturate poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-25-47 at 9P. M.
(b) Where did injury occur? 108 N. Eutaw St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No.
(d) Means of injury Injection Barbiturate Poison

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 2/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 181

G48076

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1927

G48076 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 717-Marker St.
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 year

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town 616-N. Caroline St (If outside city or town limits, write RURAL and give town)
(d) Street No. Balto. Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Minnie Bevans

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | col | Widow |

6 (b) Name of husband or wife John Bevans

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | | | hr. min. |

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Davis
13. Birthplace Accomack Co. Va.

MOTHER
14. Maiden Name Mary Kellam
15. Birthplace Accomack Co. Va.

16 (a) Informant Bessie Parrott
(b) Address 712 Mosher St Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-2-27 (month) (day) (year)
(c) Cemetery or crematory Shiloh
Location Baltimore Co.

18 (a) Funeral director Milton C. Davis
(b) Address 139 W. Hamburg St

19 (a) 2-28-1927 (Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2-27-1927, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2 1926 to 2-27-1927, and that I last saw h-r alive on 2-26-1927.

| Immediate cause of death | Duration |
|---|---|
| Chronic Valvular Heart Disease - Hypertension | 1 year |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 600 N Eutaw Date signed 2/27/27

VS 150

G48077

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 137a

G48077

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1211 LIGHT STREET
(c) Hospital or institution South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4918 Pennington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK Schneeberger

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| — | 212-07-9267 |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | M. |

6 (b) Name of husband or wife MARGARET
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 7 | 21 | hr. min. |

9. Birthplace AUSTRIA
(Town, county, and state)

10. Usual Occupation
11. Industry or business BOX CO.

FATHER
12. Name KADEN Schneeberger
13. Birthplace AUSTRIA

MOTHER
14. Maiden Name MARY WETSELBOYER
15. Birthplace AUSTRIA

16 (a) Informant Marguerite Schneeberger
(b) Address 4918 Pennington Ave

17 (a) Burial (b) Date thereof 3-1-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Anundel County

18 (a) Funeral director Joseph Rosenbergs Sons
(b) Address 602 Washington Blvd

19 (a) (b) Huntington W. Registrar
(Date rec'd by registrar)
FEB 28 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1947 at 4:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 17 1947 to Feb 27 1947, and that I last saw h. alive on Feb 27 1947

| Immediate cause of death | Duration |
|---|---|
| Uremia. | 4 days |
| Due to RENAL FAILURE | 4 days |
| Due to Prostatic Hypertrophy | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 2-28-47
Major findings of operation: PROSTATIC HYPERTROPHY
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(d) Means of injury
(e) Signature Rocco L. Laparetto M. D.
Address So. Bklo. Gen. Hosp. Date signed 2/27/47

X

0078 BH 5104 85 DH 74081

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 161c

Registered No. 619933

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 76
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 N. Calhoun St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Girl Moore

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Black | — |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2-22-47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| — | — | 2 | hr. min. |

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name? Alex. Keys
13. Birthplace ? Md.

MOTHER
14. Maiden Name Elizabeth Moore
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 27 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 28 1947 (Date rec'd by registrar) (b) Thurlow for Williams, M.D. Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb. 24 1947, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 22 1947 to Feb 24 1947 and that I last saw h.w alive on Feb. 24 1947.

| Immediate cause of death | Duration |
|---|---|
| Erythroblastosis foetalis | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard L. Dorsey M. D.
Address Johns Hopkins Hosp. Date signed 2/25/47

VS 150

G49079

BALTIMORE CITY HEALTH DEPARTMENT

BOH G 71286 **CERTIFICATE OF DEATH** 159

G49079 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address [illegible] Redwood & Green
(c) Hospital or institution: Univ Hosp 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ da
(e) Length of stay in Baltimore (yrs., mos., or days) 0

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balt. 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1321 Fremont
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** Baby boy Kennedy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race B | 6 (a) Single, married, widowed, or divorced. Baby

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/20/47

8. AGE: Years | Months | Days 1½ | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER 12. Name Wilbie Kennedy
13. Birthplace S. C.

MOTHER 14. Maiden Name Frances Kennedy
15. Birthplace S. C.

16 (a) Informant Mother
(b) Address 1321 Fremont

17 (a) ____ (b) Date thereof ____
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School FEB 27 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) FEB 28 1947 [signature] Williams H.R.
(Date rec'd by registrar) Registrar

V3 8

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/21 1947 at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/20 1947 to 2/21 1947 and that I last saw h[illegible] alive on 2/21 1947.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Prematurity | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. B. Marshall Jr. M. D.
Address Univ Hosp - Date signed 2/24/47

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G19050

S-4908 Aff G71286 1579

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Greene & Lombard
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d
(e) Length of stay in Baltimore (yrs., mos., or days) 5 d

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Green & Lombard 1012 E. Monument (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lester Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/20/47

8. AGE: Years | Months | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md (Town, county and state)

10. Usual Occupation infant

11. Industry or business ?

**FATHER**
12. Name

13. Birthplace

**MOTHER**
14. Maiden Name Mildred Smith

15. Birthplace Md

16 (a) Informant Mildred Smith
(b) Address 1012 E. Monument St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School FEB 27 1947
Location

18 (a) Funeral director Commissioner of Health
(b) Address

19 FEB 28 1947 (Date rec'd by registrar) Huntington Williams, M.D.

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 2-25 1947, at 9 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2-20 1947, to 2-25 1947, and that I last saw h[illegible] alive on 2-25 1947

| Immediate cause of death | Duration |
|---|---|
| Congenital atresia of esophagus | |
| Due to Sclerema | |
| Aspiration Pneumonia | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy 2-25-47

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23. Signature** George Mansenburg M. D.
Address University Hosp Date signed 2-25-47

VS 150

C49081

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 469

C49081 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2024 Harlem Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2024 Harlem Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Levin L. Sewell

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-09-3817

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Rachel Irene
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 7 | 15 | hr. min. |

9. Birthplace Athol Maryland (Town, county, and state)
10. Usual Occupation Movie House Manager
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace "

MOTHER 14. Maiden Name Maria Sewell
15. Birthplace Athol Md.

16 (a) Informant Rachel Irene Sewell
(b) Address 2024 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 28 47 (month) (day) (year)
(c) Cemetery or crematory Athol Baptist
Location Athol - Maryland

18 (a) Funeral director Thomas J. Dempsey Sons
(b) Address Collins + Belmont Sts.

19 (a) (Date rec'd by registrar) (b) Huntington-Wilkinson M.

vs FEB 28 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 26 1947, at 12 15 P.

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 15 1946 to Feb 26 1947 and that I last saw h[illegible] alive on Feb 25 1946

Immediate cause of death Carcinoma Pancreas — Duration ✓
Due to General abdominal — ✓
Due to Carcinoma
Other Conditions ✓

(Include pregnancy within 3 months of death)
Date of operation Feb 24 - 1947
Major findings of operation: Carcinoma Pancreas
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ (Specify type of place) While at work? ✓
(e) Means of injury ✓

23. Signature [illegible] M. D.
Address 1821 Poplar Grove Date signed 3/2/47

AB-2450 C13082

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

C13082 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9yrs- 8mos- 6days
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Charles
(c) City or town Waldorf
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** James Picha

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Widower |

6 (b) Name of husband or wife Antonia(D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept- 16- 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 5 | 4 | hr. min. |

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Antonia
15. Birthplace Czechoslovakia

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/47 (month) (day) (year)
(c) Cemetery or Crematory Sacred Heart
Location Bergen Hill Rd

18 (a) Funeral director J. F. Gahagan
(b) Address 1818 Light St

19 (a) (Date rec'd by registrar) (b) Huntingtown, Md.

FEB 28 1947

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb. 20- 1947, at 4.30PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-14 1937 to 2-20- 1947, and that I last saw him alive on 2-20- 1947.

Immediate cause of death Coronary occlusion — Duration
Due to arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edwin C. Evans M. D.
Address Balto. City Hosp. Date signed 2-27-47

X

CWK-16628 G49083

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46a

Registered No. G49083

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10- 5- 28- 26
(e) Length of stay in Baltimore (yrs., mos., or days) 36 Years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home Address
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Joseph Love or Joseph Lore

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 7-1862

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 85 | 1 | 15 | hr. min. |

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Green
15. Birthplace Ireland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/28/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Tenaganickle Rd

18 (a) Funeral director [illegible]
(b) Address 1386 Light St.

19 (a) (Date rec'd by registrar) (b) [illegible] Registrar

FEB 28 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 19 47, at 3:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 24 19 36, to Feb. 22 19 47, and that I last saw h. im alive on Feb. 22 19 47

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of Esophagus | 6 mos. |
| Due to | |
| Due to | |
| Other Conditions Arteria-Sclerosis (Include pregnancy within 3 months of death) | |

Date of operation Feb 4, 5, & 21, 1947

Major findings of operation: Palliative

of autopsy: 0

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elmer Donell M.D.
Address Balto. City Hosps. Date signed 2-27-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C19081 — 509875

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. C19081

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1622 N. Gilmore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Louis B. Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Gladys Moore

6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) 11-14-08

8. AGE: Years 39 | Months 3 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Electricians Helper

11. Industry or business

FATHER 12. Name Louis Moore
13. Birthplace N. C.

MOTHER 14. Maiden Name Irene Patterson
15. Birthplace N. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Feb. 28, 1947 (month) (day) (year)

(c) Cemetery or crematory Rock Mount N.C.
Location

18 (a) Funeral director Mrs. Katie P. Williams
(b) Address 3228 W. Lafayette Ave

19 (a) (Date received by Registrar) (b) FEB 28 1947 Registrar

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb. 25 1947, at 4:15 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Feb. 17 1947, to Feb. 25 1947, and that I last saw him alive on Feb. 25 1947.

Immediate cause of death Uremia — Duration 1 Month

Due to Hypertensive Cardiovascular Disease — 3 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23.** Signature E S Dubois M. D.

Address Johns Hopkins Hospital Date signed 2-27-47

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G19085 — 13 G 19085 — Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 705 W. Fairmount Ave.
(c) Hospital or institution: .....
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 T
(e) Length of stay in Baltimore (yrs., mos., or days) .....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County .....
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 705 W. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

**3 (a) FULL NAME** Dorothy Smith

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Col. | Single |

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 3, 1913

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 33 | 8 | 22 | ..... hr. ..... min. |

9. Birthplace A A Co. Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business .....

FATHER
12. Name Charles Smith
13. Birthplace Va.

MOTHER
14. Maiden Name Theresa Lyles
15. Birthplace Gynapolis Md.

16 (a) Informant Theresa Johnson
(b) Address 705 W. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 1, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location .....

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 822 N. Schroeder St

19 (a) ..... (Date received by registrar) 2-28-1947 Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Feb 25 1947, at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-20 1947 to 2-25 1947 and that I last saw ... alive on Feb 25 1947

| Immediate cause of death | Duration |
|---|---|
| Pulmonary TB | 4 yrs |
| Due to ..... | |
| Due to ..... | |
| Other Conditions ..... | |

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....
23. Signature [signature]
Address 1711 Pennsylvania Ave Date signed 3-6-47

VS 150

Huntington Williams, M.D.

049086

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 194a

049086 (Registered No.)

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33 & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yr.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3130 Abel Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

**3 (a) FULL NAME** Ralph Frederick Hoff

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 212-03-8462

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widower |

6 (b) Name of husband or wife: Perminia S. Hoff

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 7 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 4 | 19 | hr. min. |

9. Birthplace Reading Pa
(Town, county, and state)

10. Usual Occupation Mgr. Mfg. Lace Mfr.

11. Industry or business Electrician

FATHER
12. Name Daniel S. Hoff
13. Birthplace Delaware

MOTHER
14. Maiden Name Florence A. Brewer
15. Birthplace Penna

16 (a) Informant Daniel S. Hoff (Brother)
(b) Address 1909 Bidderman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-47 (month) (day) (year)
(c) Cemetery or crematory Charles Evans
Location Reading Penna

18 (a) Funeral director Shivelhood Memorial Co.
(b) Address 1081 W. Baltimore

19 (a) (Date rec'd by registrar) (b) Registrar

VS 191 FEB 28 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 26, 1947, at 9 45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary arteriosclerosis

Due to: Coronary thrombosis

Due to: Myocardial infarction and scarring

Due to: Generalized arteriosclerosis

Other Conditions Obesity

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George S. Merrill M.D. (Medical Examiner)
Date signed 2/26/47

X

Items marked with an asterisk (*) are required by law; all others are important. Physicians: please write the cause of death clearly and legibly.

G43087

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH √83a

G43087 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1635 E. Monument St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1635 E Monument St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie Foster

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Quclus
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25 1888

8. AGE: Years 58 | Months 3 | Days — | If less than one day hr. min.

9. Birthplace Charles County Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Wm. Barber
13. Birthplace Md.

MOTHER 14. Maiden Name Mollie ?
15. Birthplace Md.

16 (a) Informant Florence Fields
(b) Address 1635 E. Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 1 47 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County

18 (a) Funeral director Mrs Robt A. Elliott & Sons
(b) Address 1129 N. Caroline St.

19 (a) FEB (Delivered to) (b) 1947 Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 25 1947, at 12.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1947 to Feb 25 1947, and that I last saw h.e alive on Feb 21 1947

Immediate cause of death Bronchopneumonia — Duration 2 days

Due to Cerebral Hemorrhage — 2/18/47

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Neal R Lafoon M. D.
Address 1220 N. Broadway Date signed 2/27/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G43088 / 55a

Registered No. G43088

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1921 E. Biddle
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Thornton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-26-07

8. AGE: Years 39 | Months 9 | Days 29 | If less than one day: hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER
12. Name Eddie Thornton
13. Birthplace Va.

MOTHER
14. Maiden Name Susie Little
15. Birthplace Va

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL t

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/26/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Cadvary Cem.
Location A.A. County Md.

18 (a) Funeral director Dip Roth Funeral Home
(b) Address 129 N. Caroline St

19 (a) FEB 28 1947 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 25 1947, at 8:55 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 22 1947, to Feb 25 1947, and that I last saw him alive on Feb 25 1947

Immediate cause of death Pneumonia — Duration 7 days

Due to — Duration

Due to — Duration 1 year

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward J. Dybvig M. D.
Address Johns Hopkins Hospital Date signed 2-25-47

G49089

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1927

G49089 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1023 W. LEXINGTON St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 W. LEXINGTON St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE HALL BRADY

3 (b) If married, name wife NONE

3 (c) Social Security Account No. 219-05-4734

4. Sex MALE | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife WARENETTA Brady

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) MAY 6 - 1882

8. AGE: Years 64 | Months 9 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace BALTIMORE Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name JOSEPH E. BRADY SR.
13. Birthplace BALto Md

MOTHER 14. Maiden Name MARY C. WELLS
15. Birthplace BALto Md

16 (a) Informant WARENETTA BRADY
(b) Address 1023 W. LEXINGTON St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof March 3-1947 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park
Location Woodlawn Md

18 (a) Funeral director Robt. B. M. Walker
(b) Address Reed & Chester

19 (a) (Date received by registrar) (b) Registrar

FEB 28 1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH FEBRUARY 27 1947 at 2.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/26/1946 to 2/27/1947, and that I last saw him alive on 2/27/1947.

| Immediate cause of death | Duration |
|---|---|
| Congestive Heart Failure | 6 hrs. |
| Due to Valvular Heart Disease | 10 yrs. |
| Due to Arteriosclerosis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. Ambler, Jr. M. D.
Address 1933 W. Lan. St. Date signed 2/27/1947

X

G43090 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G43090

# CERTIFICATE OF DEATH ✓61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4318 Lasalle Ave.
(c) Hospital or institution: 25
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4318 Lasalle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Clara R. Everding

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | M |

6 (b) Name of husband or wife August H. Everding
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 5 | 18 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation house wife
11. Industry or business

FATHER
12. Name David G. Baynes
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margaret E. Bombarger
15. Birthplace Baltimore

16 (a) Informant August H. Everding
(b) Address 4318 Lasalle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway

19 (a) [illegible] 1947 (b) [illegible] Registrar
(Date) (Deputy Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/27 1947 at 9:10A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1947 to Feb 27 1947, and that I last saw her alive on Feb 27 1947.

| | Duration |
|---|---|
| Immediate cause of death: Hypostatic Pneumonia | 2 days |
| Due to Chronic glomerulo Nephritis | 3 years |
| Due to Cardio-Vascular Hypertension | ? |
| Other Conditions Diabetes | ? |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Mary L. Bayley
Address 1315 Eastern Ave Date signed 2/28/47

VS 150

1315

G32091

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 132

Registered No. G32091

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1103 Laurens St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 30y

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1103 Laurens St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Lebree

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-12-2357

4. Sex: M. 5. Color or race: C 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/20/1886

8. AGE: Years 60 Months 9 Days 5 If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Billy Lebree

13. Birthplace Va

MOTHER 14. Maiden Name unknown

15. Birthplace

16 (a) Informant Rebecca Lebree

(b) Address 1103 Laurens St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/26/47 (month) (day) (year)

(c) Cemetery or crematory Arlington

Location Md.

18 (a) Funeral director Geo. H. Nelson

(b) Address 1303 Pennsylvania Ave

19 (a) Date received by registrar MAR 28 1947 (b) Registration No. Washington Village, Md.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 25 1947 at 9:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from January 1947 to Jan. 25 1947 and that I last saw alive on Jan. 24 1947

Immediate cause of death Pneumonia — Duration

Due to Uremia Retention

Due to Hypostatic Congestion

Other Conditions Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.

Address 3rd & Fremont Date signed 3/27/47

VS 150

137a

G43092

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93D

Registered No. G43092

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1034 Division St.
(c) Hospital or institution: Provident Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore Saratoga St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1521 W. Saratoga St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rebecca Williams

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1893

8. AGE: Years 53 | Months 7 | Days 10 | If less than one day: hr. min.

9. Birthplace Carroll County, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Addeson
13. Birthplace md

MOTHER
14. Maiden Name Melinda Brown
15. Birthplace md

16 (a) Informant Cora Booker
(b) Address 1217 W. Lanvale St

17 (a) Burial (b) Date thereof 3/1/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus
Location md

18 (a) Funeral director Geo. B. Kelsom
(b) Address 1303 Pressman St

FEB 28 1947 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 24th 1947, at 7:50 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 23 19__ to Feb 24 1947, and that I last saw her alive on Feb 24 1947.

Immediate cause of death: Congestive Heart Failure — Duration:
Due to: Arteriosclerotic Heart Disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. J. Garfield
Address Provident Hospital Date signed 2/28/47

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

103 937 Registered No. 045093

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 N. Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Otto Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 50 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name Robert Jones Lee
13. Birthplace Virginia

MOTHER
14. Maiden Name Bettie Elizabeth Sindney
15. Birthplace Virginia

16 (a) Informant Bertha Elizabeth Slacum
(b) Address 616 N. Caroline St

17 (a) Burial (cremation, or removal) (b) Date thereof Feb. 28, 1947 (month) (day) (year)

(c) Cemetery or crematory Baltimore National Cem.
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Belvidere ave

19 (a) (Date signed) FEB 28 1947 (b) Twenty-four Belvidere Ave, Md.

VS 151

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/24 1947, at 5:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 2/25/47

X

G43091 BALTIMORE CITY HEALTH DEPARTMENT G43091

# CERTIFICATE OF DEATH 92c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 209 Allendale St.
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 209 Allendale St.
(If rural give location)
(e) Citizen of foreign country? ---------- (Yes or No)
If yes, name country ----------

3 (a) FULL NAME: Fannie Rosalie Bull

3 (b) If veteran, name war: ----------

3 (c) Social Security Account No. ----------

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Robt. Berry Bull

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1869

8. AGE: Years 78 | Months 0 | Days 25 | If less than one day ---- hr. ---- min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business ----------

FATHER
12. Name Oliver Carroll Zell
13. Birthplace Maryland

MOTHER
14. Maiden Name Fannie R. Selby
15. Birthplace Maryland

16 (a) Informant Warren Selby Bull
(b) Address 209 Allendale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/47 (month) (day) (year)
(c) Cemetery or ~~Cemetery~~ Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. A. Meyer & Son
(b) Address 805 N. Calvert St.

19 (a) FEB 28 1947 (Date received) Huntington Williams, M.D. (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 27, 1947, at 2 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 30, 1945, to Feb. 27 1947, and that I last saw her alive on Feb. 26 1947

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure - 1 month | |
| Due to chronic rheumatic endo carditis-10 to 15 yrs. | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? 2/28/47
(e) Means of injury

23. Signature George A. Kupp M. D.
Address 3030 Edmondson Ave. Date signed

VS 150

G43095

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G43095 Registered No. 131a

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 Washington Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** PERDELLA Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | Widowed |

6 (b) Name of husband or wife Richard Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-12-83

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 10 11 | 25 13 | hr. min. |

9. Birthplace Annapolis - Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Elias Parker
13. Birthplace South River, Md.

MOTHER
14. Maiden Name Harriett Thomas
15. Birthplace Chesterfield - Md.

16 (a) Informant Helen D. Kirby
(b) Address 102 Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-4-47 (month) (day) (year)
(c) Cemetery or crematory Brewer Hill
Location Annapolis, Md.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.

19 (a) FEB 28 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 191

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 25, 1947, at 5 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute congestive Cardiac failure, Congestion and edema of lungs, Generalized arteriosclerosis, Nephrosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 2-26-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G13095 — Robert Wade Ridley — G13096

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 169

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs).

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1226 South Clinton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT WADE RIDLEY.

3 (b) If veteran, name war: none.

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Mrs. Thirza R. Ridley

6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) Aug. 7-1908

8. AGE: Years 38 | Months 6 | Days 18 | If less than one day: hr. min.

9. Birthplace Morristown - Tenn
(Town, county, and state)

10. Usual Occupation Brakeman.

11. Industry or business Canton R.R.Co.

FATHER
12. Name William Ridley.
13. Birthplace Unknown

MOTHER
14. Maiden Name Virginia Cowan.
15. Birthplace Unknown.

16 (a) Informant Mrs. Thirza R. Ridley.
(b) Address 4420 Maple Ave - Halethorpe Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 28-47. (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore - Md.

18 (a) Funeral director Charles J. Dehuff.
(b) Address 3512 Frederick Ave.

19 (a) FEB 28 1947 (Date rec'd by registrar) (b) Hunting for Williams, Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 25, 1947, at 5:15 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Broken back (complete separation including cord), fractured skull, crushed chest, Multiple fractures, Crushed liver and ruptured spleen

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-25-47 at 4:30 A. M. 26/2
(b) Where did injury occur? 90' west of Clinton Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury Caught between two freight cars (in motion) (Brakeman B. & O. R.R.)

23. Signature [illegible] M.D.
Medical Examiner.

Date signed 2-25-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

File G41397

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

Registered No. G3-007

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3906 Springdale Ave
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3906 Springdale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sylvia Zemil

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | M |

6 (b) Name of husband or wife Max

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Home Work.

11. Industry or business

FATHER 12. Name Samuel
13. Birthplace Russia

MOTHER 14. Maiden Name Cole
15. Birthplace Russia

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Balto Belt & Hamilton Ave

18 (a) Funeral director Jacob Levin
(b) Address 1439 E. Balto St

19 (a) FEB 28 1947 (Date rec'd by local registrar) (b) Huntington-Williams M.H.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28/47 19 20, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-7-47 19 46 to 2-28-47 19 47, and that I last saw h alive on 2-27-47 19 47

| Immediate cause of death | Duration |
|---|---|
| Uremia | ? |
| Due to Cardio-Vascular-renal disease | ? |
| Due to Diabetes | ? |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Silverfeld M. D.
Address 714 E. Preston St Date signed 2-28-47

X

G19098

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 30D

Registered No. G19098

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1525 Fleet Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: WILLIAM B. ALDRICH

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-09-4321

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1st 1891

8. AGE: Years 55 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace: Balto. Md
(Town, county, and state)

10. Usual Occupation: Clerk

11. Industry or business

FATHER
12. Name: Frank Cann Aldrich
13. Birthplace: Delaware

MOTHER
14. Maiden Name: Anna Blair
15. Birthplace: Pa.

16 (a) Informant: Helen A. Wyatt
(b) Address: 612 St. Johns Rd

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 3/3/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location: Balto. Co. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St

19 (a) FEB 28 1947 (Date rec'd by registrar) Huntington Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27, 1947, at 10.45 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Ruptured aneurysm of aorta

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 2-27-47

VS 181

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Death Certificate

C13099 G. 71648

CWK-108814

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 157E

Registered No. C13099

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1377 N. Gilmor Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy McManus---Thelma

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 22-1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 5 | hr. min. |

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Al McManus
13. Birthplace South Carolina

MOTHER
14. Maiden Name Thelma Blakney
15. Birthplace Sounth Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location West. Balto. Md.

18 (a) Funeral director Metropolitan Funeral Home Inc.
(b) Address 921 N. Mount St.

19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 27 1947 at 2:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 22 1947 to Feb. 27 1947 and that I last saw him alive on Feb. 27 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral asphyxia | 4 hrs |
| Due to: Microcephaly, Cong. heart disease, Congenital atelectasis, Sclerema | life |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes M. D.
Address Balto City Hosp Date signed Feb 28 47

VS FEB 28 1947 Huntington Williams, M.D.

G9100

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G9100 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1206 Whatcoat St.
(c) Hospital or institution: 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 Whatcoat St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** BETTY WARE TILGHMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | |

6 (b) Name of husband or wife James Tilghman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | | | hr. min. |

9. Birthplace Essex Co. Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Tilghman
13. Birthplace Va.

MOTHER
14. Maiden Name Harriet Ware
15. Birthplace Va

16 (a) Informant Sylvia Stovall
(b) Address 2227 Madison

17 (a) Burial (b) Date thereof 3-2-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Balto. Co.

18 (a) Funeral director Jesse W. Riddle
(b) Address 436 W. Biddle St.

19 (a) FEB 28 19 (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26, 1947, at 7.25 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic heart disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 2/27/47

VS 191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49101

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1248

G49101 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3910 Claremont St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3910 Claremont St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Salvatore Cuomo

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| male | white | married |

6 (b) Name of ~~husband~~ or wife Josephine Cuomo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 9 | 2 | hr. min. |

9. Birthplace Gragnano Napoli Italy
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Antonio Cuomo
13. Birthplace Italy

MOTHER
14. Maiden Name Maddalena Negrelli
15. Birthplace Italy

16 (a) Informant Josephine Cuomo (Wife)
(b) Address 3910 Claremont St.

17 (a) Burial (b) Date thereof March 3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.
18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.
19 (a) (b) Huntington Williams M.D.
(By Coroner) Registrar

FEB 28 1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 26 1947, at 1 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 1946 to Feb. 26 1947 and that I last saw him alive on Feb. 24 1947

Immediate cause of death: General Peritonitis - Salpingitis — Duration 2 days
Due to: Carcinoma of Liver — 1 year
Other Conditions: Edema of Lungs — 3 hours
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Edmund B. Marr M. D.
Address 716 Cathedral St. Date signed 2-27-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G42102

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

✓G42102 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 505 Albemarle
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3'
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 505 Albemarle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Rose Marie Pasquariello

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Anthony Pasquariello
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV-15 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 64 | 3 | 10 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Dominic Bruno
13. Birthplace Italy

MOTHER
14. Maiden Name Anna Frantantonio
15. Birthplace Italy

16 (a) Informant Mike Pasquariello (Son)
(b) Address 217 Albemarle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 1st 47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.

19 (a) (Date first filed) (b) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 25 1947, at 7-50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 25 1947 to Feb 25 1947 and that I last saw her alive on Feb 25 1947

| Immediate cause of death | Duration |
|---|---|
| Coronary thrombosis | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Engbert
Address 10 9 Rockrose Road Date signed 2/26/47

X

G49103 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G49103

# CERTIFICATE OF DEATH 13B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 813 S. PORT ST.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 813 S. PORT ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARTIN ANDREW KENDZIERSKI

3 (b) If veteran, name war: WORLD WAR I
3 (c) Social Security Account No. 216 07 5515

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife THERESA KENDZIERSKI
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) JAN. 16, 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | 1 | 11 | hr. min. |

9. Birthplace BALTIMORE, Md. (Town, county, and state)
10. Usual Occupation LONGSHOREMAN
11. Industry or business SHIPPING

FATHER 12. Name MARTIN KENDZIERSKI
13. Birthplace POLAND

MOTHER 14. Maiden Name PRAXEDA TRYBULSKI
15. Birthplace POLAND

16. (a) Informant THERESA KENDZIERSKI
(b) Address 813 S. PORT ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-3-47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location BALTIMORE Md

18 (a) Funeral director George A. Weber
(b) Address 705 S. Bond st.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

FEB 28 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 27 FEBRUARY 1947 at 1.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 21 NOV. 1947 to 27 FEB. 1947 and that I last saw h[illegible] alive on 26 FEB 1947

| Immediate cause of death | Duration |
|---|---|
| TUBERCULOSIS, PULMONARY BILATERAL ADVANCED | 2 YRS. |
| Due to | |
| Due to | |
| Other Conditions CACHEXIA | 3 MOS. |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Krylowicz M. D.
Address 121 S. HIGHLAND Ave. Date signed 27 FEB 47

X

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2520 Boyd st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2520 Boyd st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Amie J La Montagne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed or divorced Married

6 (b) Name of husband or wife Victoria M

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 7 1880

8. AGE: Years 66 Months 4 Days 19 If less than one day hr. min.

9. Birthplace Canada (Town, county and state)

10. Usual Occupation Clerk

11. Industry or business Shipping Room

FATHER
12. Name Not Known
13. Birthplace Canada

MOTHER
14. Maiden Name Not Known
15. Birthplace Canada

16 (a) Informant Mrs Amie J La Montagne
(b) Address 2520 Boyd st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-47 (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Geo A Farley
(b) Address Fulton & Laylock

19 (a) FEB 28 1947 (Date received by Registrar) Huntington Williams Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb. 26 1947, at 6 P. M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Feb. 23 1946 to Feb. 26 1946, and that I last saw h~~im~~ alive on Feb. 26 1947.

| | Duration |
|---|---|
| Immediate cause of death Coronary Thrombosis | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter H Counihan

Address 4209 Hudson Date signed 2/28/47 M. D.

VS 150

G49105 BALTIMORE CITY HEALTH DEPARTMENT G49105
# CERTIFICATE OF DEATH 94a
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 138 W. Ostend St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 138 W. Ostend St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** AMELIA LIVINGSTON

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: John Wesley Livingston
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 3, 1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 0 | 23 | hr. min. |

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Robert Bernard
13. Birthplace: Germany

MOTHER
14. Maiden Name: Anna Marie ?
15. Birthplace: Germany

16 (a) Informant: Mr. Howard Livingston, son
(b) Address: 763 Carroll St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/47 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date received by Registrar) (b) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 26, 1947, at 1.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 29 1947 to Feb 26 1947 and that I last saw her alive on Feb 26 1947

Immediate cause of death: Coronary Thrombosis — Duration: 2 yrs.
Due to:
Due to: Cardiac Decompensation
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Duncan M. Nisbet M.D.
M. D.
Address 1703 S. Charles St Date signed 2/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

G43106 — Registered No. G43106

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4101 Ridgewood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4101 Ridgewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARGARET E. PARKER

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| - | - |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widow |

6 (b) Name of husband or wife Wm. J. Parker, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1854

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 92 | 6 | 7 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Wm. T. Markland
13. Birthplace Oxford, Md.

MOTHER
14. Maiden Name Anne Jane Phelps
15. Birthplace Balto., Md.

16 (a) Informant Miss Lillian H. Parker
(b) Address 4101 Ridgewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) FEB 28 1947 (Date rec'd by registrar) (b) Registrar, M.H.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 27, 1947 at 6:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1946 to 2/26 19 47 and that I last saw h[illegible] alive on 2/26 1947

Immediate cause of death Coronary Sclerosis — Duration years

Due to — Duration

Due to — Duration

Other Conditions Senile Cortico-Atrophy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas E Russell M.D.
Address 3902 Greenmount Ave Date signed 2/28/47

G49107

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

51B

Registered No. G49107

499888

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address Johns Hopkins Hosp

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos 27 days

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1145 Woodyear St
(If rural, give location)

(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

**3 (a) FULL NAME** Thomas Burke

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | 217-01-1592 |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | C | Married |

6 (b) Name of husband or wife Hattie

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 12.26.1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 2 | — | hr. min. |

9. Birthplace Calvert Co. Md.
(Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER 12. Name George Burke

13. Birthplace Md.

MOTHER 14. Maiden Name Malinda

15. Birthplace Md

16 (a) Informant Hattie Burke (WO

(b) Address 1145 Woodyear St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/2/47 (month) (day) (year)

(c) Cemetery or crematory St. Johns

Location Lusby, Calvert Co. Md.

18 (a) Funeral director Charles G. Cooper

(b) Address 510-12 N. Carrollton Ave

19 (a) Filed AUG 8 1947 (Deputy) for Williams Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Aug. 6 1947 at 6:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 29 1942 to Aug. 6 1947, and that I last saw h[illegible] alive on Aug. 6 1947

Immediate cause of death Carcinomia of Prostate — Duration 8 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Robert C. Mason M. D.

Address Johns Hopkins Hosp. Date signed 8-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49108 Bk# G 60353

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

106c

Registered No. G49108

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County.....
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5610 Greenhill Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Dennis Phillips

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W. | S. |

6 (b) Name of husband or wife Oct 24th 1946
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 4 | 3 | .....hr. .....min. |

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Edward Phillips
13. Birthplace Md

MOTHER 14. Maiden Name Virgina Roche
15. Birthplace Md

16 (a) Informant Mrs V. Phillips
(b) Address 5610 Greenhill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 1st 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E North Ave Ext

18 (a) Funeral director Leo B. Larson
(b) Address 1701-03 N. Patterson Park ave

19 (a)..... (b).....
(Date received by Registrar) Registrar

FEB 28 1947

V-S 190

Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1947 at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 27 1947 to Feb 27 1947, and that I last saw h.im alive on Feb 27 1947.

| Immediate cause of death | Duration |
|---|---|
| Tracheobronchitis | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Louis J. Michael M.D.
Address Sinai Hosp Date signed Feb 27 1947

X

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 167

Registered No. 049109

049109

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 219 South Paca Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Linker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ruth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28 1912

8. AGE: Years: 34 | Months: 11 | Days: - | If less than one day: hr. min.

9. Birthplace Mt Kisco Barre Penn a
(Town, county, and state)

10. Usual Occupation Armiter Winder

11. Industry or business In Landers Co

FATHER
12. Name William M. Linker
13. Birthplace Hudson Pa

MOTHER
14. Maiden Name Virgie Lohr
15. Birthplace Wilkes-Barre Penna

16 (a) Informant William M Linker
(b) Address Wilkes-Barre Penna

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 28-47 (month) (day) (year)

(c) Cemetery or crematory Wilkes Barre Penna
Location Penn sylvania

18 (a) Funeral director Williams Goth Inc
(b) Address 1217 St Paul Street

19 (a) FEB 28 1947 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 1947 at 4.5 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of base of heart involving the pulmonary artery and left lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-28-47 1:45 A.M.
(b) Where did injury occur? 219 South Paca Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Stabbing (Sharp Instrument)

23. Signature Homer J. Dennis M.D.
Medical Examiner.
Date signed 2/28/47

VS 191

X

G43110

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BC# G-59933 / 161a

G43110

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1211 Light St
(c) Hospital or institution: So Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mos

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 Chesapeake Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Helen Rose Youngbar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16 1946

8. AGE: Years | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William O. Youngbar
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Helen R. Jacobs
15. Birthplace Baltimore Md.

16 (a) Informant William O. Youngbar
(b) Address 1508 Chesapeake Ave

17 (a) Burial (b) Date thereof March 1-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Glen Haven
Location A. A. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1416 Light St.

19 (a) Date received by local registrar FEB 28 1947 (b) Signature of local registrar Huntington Williams

VS 150

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH 2/26 1947, at 11:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/23 1947 to 2-26 1947 and that I last saw h[illegible] alive on 2-26 1947

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Massive Coronary Left Lung | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Gallants Left Lung

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Brooks Wood Jr M. D.

Address 1211 Light St. Date signed 2-22-47

X

G49111 BCH 8 70193 BALTIMORE CITY HEALTH DEPARTMENT G49111
CWK-108103 CERTIFICATE OF DEATH 159 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 Days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 125 S. Gilmor Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Berlin--Thelma

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 1-1947

8. AGE: Years 0 | Months 0 | Days 21 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?
13. Birthplace

MOTHER 14. Maiden Name Thelma ?
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 2-26-47 (month) (day) (year)
(c) Cemetery or crematory B.C. Harps
Location 4940 Eastern Ave.,

18 (a) Funeral director
(b) Address

19 (a) FEB 28 1947 (Registered by registrar) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 22 1947, at 12 Noon

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1947 to Feb. 22 1947 and that I last saw him alive on Feb. 22 1947.

| | Duration |
|---|---|
| Immediate cause of death: Sepsis | 3 days |
| Due to: Premature birth | Life |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Helen E. Hughes
Address Balto City Hosp. Date signed 2-28-47

VS 150

G19112

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

48B

Registered No. G19112

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2250 E. North Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2250 E. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MABEL SCHEUERMAN

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George Scheuerman
6 (c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Mar. 19, 1894

8. AGE: Years: 52 | Months: 11 | Days: 6 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Noah B. Young
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Mary B. Puesey
15. Birthplace: Maryland

16 (a) Informant: Mr. George Scheuerman
(b) Address: 2250 E. North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) (b) Huntington Williams, M.D.
(Date received by registrar) FEB 28 1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 25, 1947 at 4.05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 4, 1946, to Feb. 25 1947, and that I last saw her alive on Feb 23, 1947.

| Immediate cause of death | Duration |
|---|---|
| Acute Nephritis | 3 days. |
| Due to Carcinoma of Uterus & General Metastases. | 3 M.s. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert L. Sinsheimer M. D.
Address 1613 E. North Ave. Date signed 2-28-47

X

G49113

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G49113 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 203 S. Highland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 203 S. Highland Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** DORA SHEELER JONES

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Frank Jones
6 (c) If alive, give age 78 years
7. Birth date of deceased (mo., day, yr.) Oct. 10, 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 4 | 18 | hr. min. |

9. Birthplace: Bedding, Pa. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Eren Sheeler
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Martha Whitman
15. Birthplace: Pa.

16 (a) Informant: Frank Jones
(b) Address: 203 S. Highland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC
(b) Address: NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b) Registrar

FEB 28 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH: FEB. 28 1947 at 5.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 29 JAN. 1947 to 28 FEB 1947 and that I last saw h.P.K alive on 27 FEB 1947

| Immediate cause of death | Duration |
|---|---|
| CEREBRAL HEMORRHAGE | 1 hr |
| ARTERIOSCLEROSIS, GENERAL | 10-20 yrs. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Benjamin Wolstatten M.D.
Address 121 S. HIGHLAND AVE. Date signed 28 FEB 47

X

505776 G49114

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 46B ✓ G49114 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Talbot
(c) City or town Easton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Amanda Norris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-18-94

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52. | 5 | 10 | hr. min. |

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name William T Norris
13. Birthplace Md.

MOTHER 14. Maiden Name Louisa R Dixon
15. Birthplace Md

16 (a) Informant Rosmda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-47 (month) (day) (year)
(c) Cemetery or crematory Spring Hill
Location Easton Md

18 (a) Funeral director Howard Morris Co,
(b) Address 108 N Main Ave.

19 (a) FEB 28 1947 (b) (Date rec'd by registrar) Registrar

VS 150

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH Feb. 28 1947 at 2.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22 1946 to Feb. 28 1947 and that I last saw h[illegible] alive on Feb. 25 1947.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of Stomach | |
| Due to | |
| with | |
| Due to Carcinomatosis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. M. Knight, Jr., M. D.
Address Date signed

Huntington Williams, M.D.

G 13175

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BC# G65283 30F

Registered No. G13175

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1111 Warner St
(c) Hospital or institution: 21
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 mos 13 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 Warner St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

**3 (a) FULL NAME** RAYMOND BUTTS

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 0 | 5 | 13 | hr. min. |

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name NORMAN JOHNSON
13. Birthplace MD.

MOTHER
14. Maiden Name ERNESTINE BUTTS
15. Birthplace MD.

16 (a) Informant MOTHER
(b) Address 1111 Warner St.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 2-6-47 (month) (day) (year) 2 PM
(c) Cemetery or crematory Baltimore City Hospitals
Location 949 Eastern Ave.

18 (a) Funeral director
(b) Address

FEB 28 1947 (Date received by Registrar) Huntington Williams M.D. (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 6 1947 at 2 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from AUG 23 1946 to FEB 6 1947 and that I last saw h[illegible] alive on FEB 6 1947

Immediate cause of death Malnutrition — Dehydration — Duration 1 wk.

Due to Hydrocephaly & Internal encephaly — 3 mo.

Due to Congenital defect and/or Congenital syphilis — life

Other Conditions Prematurity — life

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wilson E. Hughes
Address Balto City Hosp. Date signed 2-7-47

VS 150

To be Approved by the Medical Examiner Howard D. Andrews, M.D.

G19116

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

G19116 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balt.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1839 N Caroline St (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Helen F. Blake

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | W |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 10 | 29 | 2 5 hr. min. |

9. Birthplace Balt. Balt. Md. (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

**FATHER**
12. Name William J Canley
13. Birthplace Balt. Md.

**MOTHER**
14. Maiden Name Martha Maclease
15. Birthplace Balt. Md.

16 (a) Informant Raymond Blake
(b) Address 711 Beaumont Ave - Balt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 1 1947 (Month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Rd. Balt. Md.

18 (a) Funeral director John A. Moran
(b) Address 300 S E. Baltimore St.

19 (a) (Date rec'd by city reg.) FEB 28 1947 Huntington Woodstock Md.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2-27 1947 at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-21 1947 to 2-27 1947, and that I last saw her alive on 2-27 1947.

Immediate cause of death Peripheral Vascular Collapse — Duration

Due to Cerebral Vascular Accident

Due to Arteriosclerosis

Other Conditions Pneumonia-Left Lung.
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation None

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas B Lebherz M.D.
Address Mercy Hosp. Date signed 2/27/47

G49117

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46B

G49117 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen'l Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 813 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH E. CRANDALL

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed or divorced: Divorced
6 (b) Name of husband: Chas. A. Crandall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 28th 1875

8. AGE: Years 71 | Months 2 | Days 0 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Jeremiah Catterton
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Gibson
15. Birthplace Md.

16 (a) Informant Mrs. Marvin E. Thompson
(b) Address 2108 Kentucky Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/1/47 (month) (day) (year)
(c) Cemetery or crematory Glenwood
Location D. C.

18 (a) Funeral director William Cook Inc
(b) Address 1217 E. Paul St.

19 (a) 3-1-1947 (Date rec'd by local Reg.) Huntington Williams MD Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/28 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw her alive on 2/28 1947

| Immediate cause of death | Duration |
|---|---|
| Cardio-respiratory failure | |
| Peritonitis | |
| Due to Carcinoma of Stomach | |
| Due to | |
| Other Conditions Generalized carcinomatosis Extreme Cachexia | |

(Include pregnancy within 3 months of death)
Date of operation Exploratory laparotomy 2/
Major findings of operations Carcinoma of stomach
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roy B. Turner M. D.
Address West Balto. Gen Hosp Date signed

VS 150

C49118

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Register No. C49118

510710 Mt G58523 / 157E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1225 N Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Dolores A Gamble

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | NONE |

| 4. Sex | 5. Color or race | 6 (a) Single, ~~married, widowed, or divorced~~ |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-7-46

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 4 | 20 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Harry Gamble
13. Birthplace Ky.

MOTHER
14. Maiden Name Francis Bayless
15. Birthplace Ohio

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 3/1/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

MAR 1 - 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb. 27 1947 at 7.30 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Feb. 26 1947 to Feb. 27 1947 and that I last saw her alive on Feb. 27 1947.

| Immediate cause of death | Duration |
|---|---|
| Acute cardiac failure | |
| Lungs - tracheo-bronchitis | |
| Due to Congenital Heart disease (agenetic) | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Greenhouse M. D.
Address Johns Hopkins Hosp. Date signed 3-4-47

X

G49119

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

93E

Registered No. G49119

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland 1480 N. Caroline
(b) Street address
(c) Hospital or institution St Josephs Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 S. Savage St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** EARL KLEPSIG

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6 1915

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 32 | 1 | 21 | hr. min. |

9. Birthplace New Orleans (Town, county, and state)

10. Usual Occupation

11. Industry or business Unemployed

FATHER
12. Name Otto J. Klepsig
13. Birthplace Chicago

MOTHER
14. Maiden Name Mary B. Hoffman
15. Birthplace New Orleans

16 (a) Informant James Klepsig
(b) Address 519 S Savage St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 3. (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (This space to be filled in by the Registrar) Mar 1 1947 Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2-27 1947 at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-26 1947 to 2-27 1947 and that I last saw him alive on 2-27 1947

| Immediate cause of death | Duration |
|---|---|
| Pneumonia | |
| Due to Myocarditis | |
| Due to Dyptheria adiposa Genitalis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Anthony J. Owen, M.D.
Address 519 Josephs Date signed 2/28/47

VS 190

G19120

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G49120

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1616 Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helena Burkard.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-16-3537

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 2, 1876

8. AGE: Years 70 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Novelty

FATHER 12. Name David Burkard

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Johanna Rasche

MOTHER 15. Birthplace Germany

16 (a) Informant Mary Burkard

(b) Address 1616 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 3, 1947 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location City

18 (a) Funeral director Mrs. John W. Teufel & Son

(b) Address 5311 Edmondson Ave.

19 Filed MAR 1 1947 Registrar Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 28 1947, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/19 1947, to 2/28 1947, and that I last saw h[illegible] alive on 2/27 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral Embolism | |
| Due to myocarditis | |
| Due to Hypertension | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F E Poulton M D

Address 3969 Lawson Blvd Date signed 2/28/47 M. D.

VS 150

049121

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. 049121

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 601 N. Bentalou St.
(a) Baltimore City, Maryland
(b) Street address 601 N. Bentalou St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 601 N. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Chrissie V. Harrison.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charles W. Harrison

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1876

8. AGE: Years 70 | Months 7 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace Frederick Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Elias Grove.
13. Birthplace Unknown

MOTHER
14. Maiden Name Henrietta Hahne
15. Birthplace Germany

16 (a) Informant Marshall L. Grove.
(b) Address Frederick Md. R.F.D-1.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof MAR. 3, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet.
Location Frederick Md.

18 (a) Funeral director George Weber & Son
(b) Address 2503 Edmondson Ave.

19 (a) [illegible] (b) Clinton Williams, M.D.
Registrar

MAR 1 1947
Date rec'd by Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 28, 1947 at 6.45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/10/46 19__, to 2/28 19 47 and that I last saw her alive on October 9 19 46

Immediate cause of death: Cerebral Hemorrhage — Duration: ____

Due to: Hypertensive cardiovascular disease. — Duration: 12yrs.

Due to: ____

Other Conditions: ____

(Include pregnancy within 3 months of death)

Date of operation: ____

Major findings of operation: ____

of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Daniel J. Schwartz M. D.
Address 2320 Eutaw Place Date signed 2/28/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49122

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1310

Registered No. G49122

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 313 S. Bruce St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 S. Bruce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ella B. Addison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harry T. Addison

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1891

8. AGE: Years 56 | Months 1 | Days 13 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER
12. Name William T. Emmart
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Barnett
15. Birthplace Md.

16 (a) Informant Mr. Harry T. Addison
(b) Address 313 S. Bruce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch. 3/47. (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry A. Mutschele
(b) Address 4101 Edmondson Ave.

MAR 1 - 1947 (Date rec'd by registrar) Waiting for Affidavit Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 28/47. 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 46, to Feb 19 47, and that I last saw h alive on 28 Feb 19 47.

Immediate cause of death: Pulmonary edema — Duration

Due to cardiac failure

Due to coronary occlusion

Other Conditions Chronic nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H H Bayless M. D.
Address 1600 Wilkens Ave. Date signed 28 Feb 47

X

G49123

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93

Registered No. G49123

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 625 Edgewood St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 625 Edgewood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mabel Coggins

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late George E. Coggins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1874

8. AGE: Years 72 | Months 11 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER
12. Name William H. Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Julia Foxwell
15. Birthplace Md.

16 (a) Informant Louis E. Coggins
(b) Address 810 Lyndhurst St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 1/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location 2930 Frederick Rd.

18 (a) Funeral director Harry A. Tuttle
(b) Address 4101 Edmondson Ave.

MAR 1 - 1947 (Date rec'd by registrar) (b) Huntington Williams

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 2-26 1947 at 10:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2 1946, to 2-26 1947, and that I last saw h[illegible] alive on 2-26 1947

| Immediate cause of death | Duration |
|---|---|
| Chronic Myocardial Degeneration | 2 yr. |
| Due to Arteriosclerosis | 2 yr. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Ballard M. D.
Address 707 Fort Ave. Date signed 2-27-47

G49124

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

Registered No. G49124

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 558 W. Hoffman St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 558 W. Hoffman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Lee Jones

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | Divorced |

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4 - -. 1905

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 41 | 10 | | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name Charles Brady
13. Birthplace Maryland

MOTHER
14. Maiden Name Rose Jones
15. Birthplace Maryland

16 (a) Informant Mae Walters
(b) Address 558 W. Hoffman St

17 (a) Burial (b) Date thereof 3 2 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania ave

19 (a) Date rec'd by local registrar MAR 1 1947 (b) Registrar Huntington Williams

VS 181

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/27 1947, at 2:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Subrinka M.D.
Medical Examiner.
Date signed 2/28/47

937

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49125

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

131a

Registered No. G49125

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 524 E. Clement -
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 524 E. Clement (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Harry E. Wroten

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-01-6795

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age —

7. Birth date of deceased (mo., day, yr.) July 29, 1881

8. AGE: Years 65 | Months 6 | Days 28 | If less than one day hr. min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation Ret Farmer

11. Industry or business —

FATHER
12. Name William Wroten
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Louise Rash
15. Birthplace Balto Md.

16 (a) Informant Mrs. Gertrude V. Sheeler
(b) Address 524 E. Clement St. Balto 30 Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 7 '47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. G. Co. Md.

18 (a) Funeral director A. Howard Evans
(b) Address 1400 E. Pleasant Balto 30 Md.

19 (a) (Date received by Registrar) MAR 1 1947 (b) Harrington Williams M.D. Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 28, 1947, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 13, 1947 to Feb. 28, 1947 and that I last saw him alive on Feb. 28, 1947.

| Immediate cause of death | Duration |
|---|---|
| (a) Coronary occlusion | |
| Due to (b) Hypertensive cardio-vascular disease. | |
| Due to (c) Senile arteriosclerosis. | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
Signature H. L. Friedman M.D.
Address 1317 Light St. Date signed 3/2/47

X

G19126

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46E

Registered No. G19126

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 47 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto
(c) City or town Pikesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 Waldren ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Agnes J. Couch

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. — |
|---|---|

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| female | white | married |

6 (b) Name of husband or wife Clarence Couch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1899

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 47 | 4 | 1 | hr. min. |

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER: 12. Name Christopher Kretzer
13. Birthplace Penna.

MOTHER: 14. Maiden Name Phoebe Rump
15. Birthplace Penna.

16 (a) Informant Hosp. Record
(b) Address Calvert St. Balto md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 3-47 (month) (day) (year)
(c) Cemetery or crematory St. Wendelinus
Location Pittsburg Pa.

18 (a) Funeral director Frank H. Yeuell
(b) Address Pikesville, Maryland.

19 (a) MAR 1 1947 (Date received by Registrar) (b) Hilton Williams, M.D.

## MEDICAL CERTIFICATION

46

20. DATE OF DEATH 2-28-47 19 at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 19 47 to Feb 28 19 47 and that I last saw h 4 alive on 2-28 19 47

| Immediate cause of death | Duration |
|---|---|
| respiratory failure | |
| Due to metastatic carcinoma | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation 2-13-47
Major findings of operations: metastatic carcinoma
of autopsy:

over

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James J. Gulash M. D.
Address Mercy Hosp Date signed 2-28-47

VS 150

X

G49127

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G49127

Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 576 W. University Pkwy.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 576 W. University Pkwy. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** JOHN EDGAR SWALLOW

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Florence M. Swallow
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 13, 1875

8. AGE: Years 72 | Months 0 | Days 15 | If less than one day: hr. min.

9. Birthplace: Hagerstown, Md. (Town, county, and state)
10. Usual Occupation: D. D. S.
11. Industry or business: Self

FATHER
12. Name: John E. Swallow
13. Birthplace: Carthage, Ohio

MOTHER
14. Maiden Name: Mary E. Snyder
15. Birthplace: Funkstown, Md.

16 (a) Informant: Miss Effie B. Swallow
(b) Address: 3208 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

MAR 1 - 1947 (b) [illegible] Registrar
(Date rec'd by registrar)

VS 190

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28, 1947, at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 27 1947, to Feb. 28 1947, and that I last saw him alive on Feb. 28 1947

| Immediate cause of death | Duration |
|---|---|
| Myocardial Failure | |
| Due to Massive Coronary thrombosis | 5 hours |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 119 Medical Arts Date signed 3-1-47

G49128

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No. G49128

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2646 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2646 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** JOHN K. HODDINOTT

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | Widower |

6 (b) Name of husband or wife Martha F. Hoddinott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1856

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 90 | 9 | 17 | hr. min. |

9. Birthplace Harpers Ferry, W. Va.
(Town, county, and state)
10. Usual Occupation Electrician - Locksmith
11. Industry or business Retired

FATHER
12. Name Charles Hoddinott
13. Birthplace England

MOTHER
14. Maiden Name Henrietta Knontz
15. Birthplace Frederick Co., Md.

16 (a) Informant Mr. Edgar L. Hoddinott
(b) Address 2646 W. North Ave.

17 (a) Burial (b) Date thereof 3/3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 1 - 1947 (Date rec'd by registrar) waiting for Williams

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 28, 1947 at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 20 1947, to Feb. 28 1947, and that I last saw h im alive on Feb. 27 1947.

| Immediate cause of death | Duration |
|---|---|
| Chronic Myocarditis | 2 |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 2757 Wilson Date signed 3/1/47

VS 150

G49129

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G49129

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3614 Oakmont Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Harford Co.
(c) City or town Aberdeen
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Elmer Addison Duff

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widower |

6 (b) Name of husband or wife Sarah Agnes Duff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 5 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 11 | 13 | hr. min. |

9. Birthplace Harford Co. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Beatrice Garrett
(b) Address 3614 Oakmont Ave

17 (a) Burial (b) Date thereof 3-4-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Harford Memorial
Location Washington Blvd

18 (a) Funeral director Lorenz Bros
(b) Address 5005 Belair Rd

19 MAR 1 - 1947 (b) Harry Williams Registrar
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 1947, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 24 1947, to Feb 28 1947, and that I last saw h[illegible] alive on Feb 24 1947.

Immediate cause of death: Acute Coronary Occlusion — Duration 1 day
Due to: Coronary Thrombosis
Due to: Senility
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation no
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Charles J Meeks M. D.
Address 5716 Park Heights Ave Date signed Mar 1 47

VS 150

G49130

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 939

Registered No. G49130

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4417 Wickford Road
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4417 Wickford Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Hanson Mitchell

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Mary McDowell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 2 | 20 | hr. min. |

9. Birthplace LaPlata, Md. (Town, county, and state)
10. Usual Occupation mechanical engineer
11. Industry or business

FATHER: 12. Name John H. Mitchell
13. Birthplace Md.

MOTHER: 14. Maiden Name Lillie T. Jeniser
15. Birthplace Md.

16 (a) Informant Mary McDowell Mitchell
(b) Address 4417 Wickford Road

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 3/2/47 (month) (day) (year)
(c) Cemetery or ~~Cemetery~~ Mt. Rest
Location LaPlata, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 MAR 1 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 28 1947 at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1936 to Feb 28 1947 and that I last saw deceased alive on Feb 27 1947.

| | Duration |
|---|---|
| Immediate cause of death: Myocarditis; Arteriosclerosis | Stated |
| Due to: Hypertension | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H H Moody M.D.
Address 1403 Park Ave. Date signed 2/28/47

VS 150

G49131 D. Cooper

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

91 B

G49131 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 641 W. Conway st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 y
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 641 W. Conway st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Arthur Benton Sanford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years 59 | Months | Days | If less than one day hr. min. 1888

9. Birthplace Davenville, Md (Town, county, and state)

10. Usual Occupation Handy Man

11. Industry or business

FATHER 12. Name Archie B. Lanford
13. Birthplace Davenville, Md

MOTHER 14. Maiden Name Mary Ann Hilaway
15. Birthplace Anne Arundel Co., Md

16 (a) Informant Rev. John Lanford
(b) Address Annapolis, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/47 (month) (day) (year)

(c) Cemetery or crematory
Location Davenville, Md.

18 (a) Funeral director Hicks Funeral Home
(b) Address 43 N. West. St. Annapolis Md

MAR 1 - 1947 (Date rec'd by Registrar) Hunting for Williams Registrar

**MEDICAL CERTIFICATION**

2/27/47 9 AM

20. DATE OF DEATH 2-27 1947, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-20 1947, to 2-27 1947, and that I last saw h[illegible] alive on 2-27 1947

| Immediate cause of death | Duration |
|---|---|
| Acute Endocarditis | 6 Week |
| Due to | |
| Due to | |
| Other Conditions Aort Stenosis | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonny C. Cooper M. D.
Address 706 E Chase St Md Date signed 3-1-47

VS 150

X

G49132

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 309

Registered No. G49132

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Green & Redwood Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1328 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Frederick E. Boyd.

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M. | W | Married |

6 (b) Name of husband or wife Margaret E. Boyd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 11 | | hr. min. |

9. Birthplace Md Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Real Estate

FATHER
12. Name John E. Boyd.
13. Birthplace New York

MOTHER
14. Maiden Name Amanda Bramwell
15. Birthplace Md.

16 (a) Informant Mrs. Margaret E. Boyd.
(b) Address 1328 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3800 Frederick Ave.

18 (a) Funeral director John J. Brown & Son
(b) Address 601-03 Hollins St.

19 MAR 1 - 1947 Huntington Williams, M.D. Registrar
(Date received by registrar)

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 2-27-47 19 , at 10:05 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2-24-1947, to 2-27-1947, and that I last saw him alive on 2-27-1947.

| Immediate cause of death | Duration |
|---|---|
| Dissecting Aneurysm Abdominal Aorta & Thoracic Aorta | |
| Due to Hypertension Atherosclerosis Chronic | |
| Due to Myocardial | |
| Other Conditions Arteriosclerosis and Hemiatrophia. | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Dissecting Aneurysm Aorta

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23. Signature** Charles H. Hardenbergh M. D.
Address University Hospital Date signed 2-28-47

VS 150

G49133

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G49133 Registered No. 9262

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street city
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) ?

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Washington
(c) City or town Hagerstown, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** Emma McGinley

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | white | widowed |

6 (b) Name of husband or wife Edward McGinley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 10 11 | 18 | hr. min. |

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Factory Worker
11. Industry or business

FATHER
12. Name Wm. Cunningham
13. Birthplace Md

MOTHER
14. Maiden Name Sara Reynolds
15. Birthplace Pennsylvania

16 (a) Informant Little Sisters of the Poor
(b) Address 1201 Valley Street City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 3 1947 (month) (day) (year)
(c) Cemetery or crematory Rose Hill
Location Hagerstown, Md.

18 (a) Funeral director E. M. Sutter and Son
(b) Address Hagerstown, Md.

19 (a) 1947 (Date received by registrar) (b) Washington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 1 1947, at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1947, to March 1 1947, and that I last saw her alive on Feb 28 1947.

| Immediate cause of death | Duration |
|---|---|
| Edema Lungs | 2 days |
| Due to Mitral Stenosis | 5 yrs |
| Due to | |
| Other Conditions Arteno-Sclerosis | 5 yrs |

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C Bill Hall
Address 1631 E North ave Date signed 3/1/47 (M.D.)

VS 3

G49134 | BALTIMORE CITY HEALTH DEPARTMENT | G49134

# CERTIFICATE OF DEATH 49a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd St. & Guilford Ave.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 71 dys
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2919 Lorraine Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** William W. Mund

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-7930

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Henry W. Mund
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-22-1901

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 45 | 9 10 | 28 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Buyer
11. Industry or business DeLevinson Co.

FATHER
12. Name Louis H. Herling
13. Birthplace Russia

MOTHER
14. Maiden Name Kay Brown
15. Birthplace Russia

16 (a) Informant Hospital Records
(b) Address 33rd St. & Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 2 /47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Remt.
Location 3600 E Balto St.

18 (a) Funeral director SOL LEVINSON & BROS
(b) Address 112-26 W. North Ave

19 (a) (Date received by registrar) Wilmington Williams M.D. Registrar

MAR 2 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28, 1947 at 7:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 19, 1946 to Feb. 28, 1947 and that I last saw h.er. alive on Feb. 28, 1947

| Immediate cause of death | Duration |
|---|---|
| Papillary adenocarcinoma of the ovary | 7 |
| Due to | |
| Due to | |
| Other Conditions Generalized carcinomatosis | 7 |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN** Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elliott J. Mayer M. D.
Address Union Memorial Hospital Date signed 3-2-47

X

G49135

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

✓ G49135 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28a
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 211 Westwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** BENJAMIN-MILLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | | | hr. min. |

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER 12. Name Wolf

13. Birthplace Russia

MOTHER 14. Maiden Name Gesue

15. Birthplace Russia

16 (a) Informant Nidda Romanoff

(b) Address Ruxton Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-2-47 (month) (day) (year)

(c) Cemetery or crematory Hebrew Herring Run

Location

18 (a) Funeral director Jack Lewis Inc

(b) Address 1409 E Dalto St

19 (a) 1947 (Date received by registrar) (b) Huntington Williams MD Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 28 1947, at 5:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George L. Merrill M.D. Medical Examiner.

Date signed 2/28/47

VS 151

Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49136

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G49136 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3622 Lunell Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3622 Lunell Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Goldie Becker Tossman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | M |

6 (b) Name of husband or wife Louis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Home Work
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-2-47 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Fernon Hill Rd.

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St.

19 (a) 2-[illegible]-1947 (Date rec'd by registrar) (b) Washington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Feb 28 1947, at 6 P.M. 05

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946, to Feb 28 1947 and that I last saw h.e.r alive on Feb 28 1947

| Immediate cause of death | Duration |
|---|---|
| (a) Chr AA Heart failure | 8 mo |
| Due to (b) Arterio-Sclerosis & Arteriosclerotic | |
| Due to (c) heart disease | 5 years |
| Other Conditions | |

(Include pregnancy within3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Jaw Cohen M. D.
Address 1804 Eutaw Place Date signed 3/4/47

VS 150

G49137 ✓ G49137

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution:
Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2100 Cotton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Francis Albert LaPorte

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 1 | 10 | hr. min. |

9. Birthplace Baltimore City
(Town, county, and state)
10. Usual Occupation Banker
11. Industry or business

FATHER
12. Name Henry LaPorte
13. Birthplace Baltimore City

MOTHER
14. Maiden Name Virginia Meseke
15. Birthplace Baltimore City

16 (a) Informant Robert H. LaPorte
(b) Address Glyndon, Md.

17 (a) Burial (b) Date thereof Mar. 4, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Balto. Co.

18 (a) Funeral director J.F. Eline & Sons
(b) Address Reisterstown, Md.

MAR 2 - 1947 (a) (b)
(Date rec'd by registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 1 1947, at 11 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 22 1946, to March 1 1947, and that I last saw h alive on 19

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 2 yr |
| Due to Hypertension | |
| Arteriosclerosis | 5 yrs |
| Due to | |
| Other Conditions Myocardial failure | 4 mos |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frederick Leaf, M. D.
Address Temple Gardens Apts. Date signed 3-2-47

X

G49138

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

937

G49138

Registered No.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address 1200 Valley St. city

(c) Hospital or institution:

Little Sisters of the Poor

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days

(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1200 Valley St

(If rural give location)

(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** Josephine Anello

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Angelo Anello

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 24, 1863

8. AGE: Years: 84 | Months: 8 | Days: 7 | If less than one day: hr. min.

9. Birthplace: Italy (Town, county, and state)

10. Usual Occupation: housekeeping

11. Industry or business

FATHER

12. Name: Anthony Calvarese

13. Birthplace: Italy

MOTHER

14. Maiden Name: Marie Rosa Rizzo

15. Birthplace: Italy

16 (a) Informant: Little Sisters of the Poor

(b) Address: 1200 Valley St. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 3 1947 (month) (day) (year)

(c) Cemetery or crematory: Holy Redeemer

Location: Baltimore

18 (a) Funeral director: Rita Wiedefeld

(b) Address: 900 East Biddle St

19 (a) Date received by Local Registrar MAR 5 1947 (b) Waring for Williams, M.D.

VS 1

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Mch 1 1947, at 2:30 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from Feb 22 1947, to Mch 1 1947, and that I last saw her alive on Feb 28 1947.

| Immediate cause of death | Duration |
|---|---|
| Edema Lungs | 1 day |
| Due to: Chronic Myocarditis | 1 yr. |
| Due to: | |
| Other Conditions: Arteriosclerosis | 5 yrs. |

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence:

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature: E Gill Hall M. D.

Address: 1631 E North Ave Date signed: 3/14/47

X

G49139

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

59B

G49139 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3940 Lowndes Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3940 Lowndes Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Kerr Dunlap Heard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Osborne O. Heard

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) November 19, 1888

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 3 | 9 | hr. min. |

9. Birthplace Frederick, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name O. K. Dunlap
13. Birthplace Rockbridge County, Va.

MOTHER
14. Maiden Name Kate
15. Birthplace Rockbridge County, Va.

16 (a) Informant Mr. Osborne O. Heard
(b) Address 3940 Lowndes Ave.

17 (a) Cremation (b) Date thereof March 3, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miles L. Donovan
(b) Address 2010 Liberty Heights Ave.

19 (a) (b) Washington Williams, M.D.
(Date rec'd by registrar) Registrar

MAR 2 - 1947

Vs 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 1947 at 1.20P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1946 to 28 Feb 1947 and that I last saw her alive on 27 Feb. 1947.

| Immediate cause of death | Duration |
|---|---|
| Acute Cardiac dilatation | 1 hr. |
| Due to Arthritis Deformans | 5 yrs. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lloyd C. Saylor M. D.
Address 3902 Greenmount Ave. Date signed Mar 1 1947

X

G49140

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G49140 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1211 Lt H St.
(c) Hospital or institution: So. Balto. Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 Primrose Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Annie Spain SPIERS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife WM SPIERS

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) June 13 1869

8. AGE: Years 78 | Months 1 | Days 16 | If less than one day hr. min.

9. Birthplace VIRGINIA.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name NOAH THOMAS
13. Birthplace VA

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Harmon Spain
(b) Address 806 PRIMROSE AVE

17 (a) REMOVAL (burial, cremation, or removal) (b) Date thereof MARCH 2-4 (month) (day) (year)
(c) Cemetery or crematory NORFOLK. VA
Location VA

18 (a) Funeral director Bernard C Harker
(b) Address 121 E West St

19 (a) 1947 (Date received by registrar) (b) Huntington Williams Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 3-1 1947, at 2 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-28 1947, to 3-1 1947, and that I last saw her alive on 3-1 1947

Immediate cause of death: Cardiac Failure.

Duration

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions Intestinal Obstruction Diabetes Mellitus.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Lundeen M. D.
Address 1211 Light St Date signed 3-1-47

VS 150

93D

G49141

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G49141

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2625 Maryland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2625 Maryland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Timothy Gavin

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Husband |

6 (b) Name of husband or wife Mary A. Gavin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 84 | | | hr. min. |

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business St. Mary's Seminary

FATHER
12. Name Wm. Gavin
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Victor Gavin
(b) Address 2626 Md. Ave.

17 (a) Burial (b) Date thereof 2-28-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Cty.

18 (a) Funeral director Sudbrink & Son
(b) Address Greenmount & Lan. & 22nd St.

19 (a) 2-27-47 (Date received by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 2/25/1947, at 7a M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/25/1947 to 2/25/1947 and that I last saw h[illegible] alive on 2/24/1947

| Immediate cause of death | Duration |
|---|---|
| Myocardial Insufficiency | 2 days |
| Due to Myocarditis | 2 years |
| Due to Senile Arteriosclerosis | 10 yrs |
| Other Conditions Diabetes (Severe) | 15 yrs |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature THOMAS F. WHITE
Address 522-522 St. Date signed 2/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

VS 150

Huntington Williams, Md.

G49142

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

467

G49142 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 334, Calvert Street
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Florida (b) County Broward
(c) City or town Hollywood
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1945 Adams St ~~E~~ (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

**3 (a) FULL NAME** JOHN WILLIAM WHELAN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Eugenia Marie Whelan
6 (c) If alive, give age: 53 years
7. Birth date of deceased (mo., day, yr.): Feb. 14, 1886
8. AGE: Years: 61 | Months: 0 | Days: 16 | If less than one day: — hr. — min.
9. Birthplace: Minnesota (Town, county, and state)
10. Usual Occupation: Lawyer
11. Industry or business:

FATHER
12. Name: Jeremiah Whelan
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Anna Whelan
15. Birthplace: Canada

16 (a) Informant: John William Whelan (dec'd.)
(b) Address: 1945 Adams St, St. Petersburg, Fla.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 2 47 (month) (day) (year)
(c) Cemetery or crematory — ? —
Location: probably Mem. Hollywood - Fla.
18 (a) Funeral director: Chilvers & Mohan Company
(b) Address: 108 W. North Ave.
3 (c) 1947 (Date received by registrar) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 2 1947, at 6:11 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 11 1947, to March 2 1947 and that I last saw him alive on March 1 1947.

| | Duration |
|---|---|
| Immediate cause of death: Cardio respiratory failure. | |
| Due to: Post-operative Intestinal + Peritonitis | 2 days |
| Due to: Wound dehiscence | 4 days |
| Other Conditions: Adenocarcinoma of rectum. | |

(Include pregnancy within 3 months of death)
Date of operation Feb. 18, 1947
Major findings of operation: Adenocarcinoma of rectum.
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature: James McC. Finney M. D.
Address: Union Memorial Hospital Date signed: 3-2-47

VS 150

X

G49143 BC# G 56185

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

157E

✓ G49143

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 123 Mosher St
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Mo.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1232 W Mosher (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ralph Lawrence Windle Jr. ✓

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: Single

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept-11-1946

8. AGE: Years 0 | Months 5 | Days 18 | If less than one day: 20 hr. ____ min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: none

11. Industry or business: none

FATHER 12. Name: Ralph L. Windle

13. Birthplace: St Louis Mo.

MOTHER 14. Maiden Name: Rose E. Wiss

15. Birthplace: Sparks Md

16 (a) Informant: Mr R. L. Windle (Father)

(b) Address: 123 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-3-47 (month) (day) (year)

(c) Cemetery or crematory: New Cathedral

Location: Baltimore

18 (a) Funeral director: Sullivan Mortuary Co.

(b) Address: 108 W Mt Royal Ave.

19 (a) 1947 (Date received by registrar) (b) Harrington Hillman, Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: March 1 1947, at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 26 1947 to Mar 28 1947, and that I last saw him alive on Mar 28 1947

Immediate cause of death: Bronchopneumonia

Due to: Heart disease (Congenital)

Duration: 6 days Life

Due to:

Other Conditions: Meningococcemia.

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury:

23. Signature: Henry Lyman Mettle M. D.

Address: 1229 E Belvedere Dr

Date signed: March 1 1947

X

Da G49144 (

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G49144 Registered No. 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1118 Low St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5'
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 Low St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Minty Joyner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: W.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1869

8. AGE: Years 78 | Months 0 | Days 8 | If less than one day hr. min.

9. Birthplace Virginia (town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER — 12. Name William Seymons
13. Birthplace Va

MOTHER — 14. Maiden Name Rosie Scott
15. Birthplace Va

16 (a) Informant Catherine Scott
(b) Address 1118 Low St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 4, 1947 (month) (day) (year)

(c) Cemetery or crematory Accomac
Location Accomac Co Va

18 (a) Funeral director Elroy O. Wilson
Address 1000 Liberty Ave Huntington Williamson, W. Va.

MAR 2 1947

19 (a) (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION** 4 PM 2/24/47

20. DATE OF DEATH 2-26- 1947, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-15-1946 to 2-26-1947 and that I last saw h[illegible] alive on 2-25-1947.

Immediate cause of death Coronary Renal-Vascular disease — Duration Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M.D. Conquest M. D.
Address 611 N. Conquest Date signed 3-1-47

VS 130

X

G49145

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 52a

Registered No. G49145

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3826 Brooklyn Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6½ yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3826 Brooklyn Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** Marie Virginia Norton

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Widowed |

6 (b) Name of husband or wife John J. Norton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-25-88

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 5 | 3 | hr. min. |

9. Birthplace Chichester Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James O. Jones
13. Birthplace Chichester Md.

MOTHER
14. Maiden Name Wakefield Rogers
15. Birthplace Wakefield Md.

16 (a) Informant Mrs. Mary Wakefield
(b) Address 3826 Brooklyn Ave. Balto Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 3. 1947 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Laurel Md.

18 (a) Funeral director Alex W. Hill & Sons Colm
(b) Address Laurel Md.

19 MAR 3 - 1947 (Date rec'd by registrar) Registrar

VS 3

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 1947, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1946, to February 1947, and that I last saw h[illegible] alive on Feb. 28 1947.

| Immediate cause of death | Duration |
|---|---|
| Adeno carcinoma of left kidney | 1 yr. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy Adeno carcinoma of left kidney

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P. J. Ammaldi M. D.
Address 1409 Gov. Ritchie Highway Signed 2-29-47 M. D.

G19146

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

309

Registered No. G19146

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood + Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 302 W. Hoffman St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Foster.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col.

6 (a) (Single) married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/14/27

8. AGE: Years 22 | Months 3 | Days 1 | If less than one day ____ hr. ____ min.

9. Birthplace Prince Edward Co. Dollington Va.
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Cornelia Mc Kee
15. Birthplace Prince Edward Co. Dolington Va.

16 (a) Informant Cornelia Mc Kee
(b) Address 302 W. Hoffman St

17 (a) Removal (b) Date thereof 3/4/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Trump Baptist
Location Dolington Bridge, Va.

18 (a) Funeral director Charles Alexander
(b) Address 1208 Mc Culloh St.

19 MAR 3 - 1947 Huntington Williams, M.D.
(Date received by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1947, at 2 30/A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 25 1947 to Mar. 1 1947 and that I last saw her alive on Mar 1 1947.

| | Duration |
|---|---|
| Immediate cause of death Uremia | 2 days. |
| Due to Renal Calculi. | 3 days. |
| Due to Malaria. | 4 days. |
| Other Conditions (over) | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gerald A. Martin M. D.
Address Univ. Hospital Date signed 3-1-47

VS 150

X

G49445 G49147

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13B

Registered No. G49147

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 8- 21-
(e) Length of stay in Baltimore (yrs., mos., or days) 23 Yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 929 Madison Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Thomas Seasons

3 (b) If veteran, name war

3 (c) Social Security Account No. 223-20-7945

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23-1923

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 23 | 9 | 4 | hr. min. |

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Gus Seasons
13. Birthplace North Carolina

MOTHER
14. Maiden Name Eugenia ?
15. Birthplace Virginia

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-3-1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location

18 (a) Funeral director James a Stayes
(b) Address 1142 w Stiles St

19 (a) (Date rec'd by registrar) MAR 3 1947 Huntington Williams M.D.

VS 15

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 27 19 47, at 11:20 A

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 19 45, to Feb. 27 1947, and that I last saw him alive on Feb. 27 19 47.

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia | 2 days |
| Due to | |
| Contributing pneumonectomy | |
| Due to | |
| Other Conditions Bilateral pulmonary tuberculosis. | |

(Include pregnancy within 3 months of death)

Date of operation 2/25/47

Major findings of operation: Pulmonary tuberculosis with cavitation, left

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. V. Gibbs M. D.
Address Balto. City Hospitals Date signed 2/28/47

X

G49148

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

139a

G49148

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address 1514 Division ST

(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 4 years

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1022 Leadenhall ST (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Marietta Gester

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | N | M |

6 (b) Name of husband or wife Wm Gester

6 (c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.) 4-12-26

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 20 | 9 | 12 | hr. min. |

9. Birthplace Concord, N.C. (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER

12. Name Ed Crawford

13. Birthplace S.C.

MOTHER

14. Maiden Name Minnie Ford

15. Birthplace S.C.

16 (a) Informant Minnie Crawford

(b) Address 1022 Leadenhall St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/2/47 (month) (day) (year)

(c) Cemetery or crematory Concord

Location North Carolina

18 (a) Funeral director Isaiah L. Brown & Son

(b) Address 108 W Monument St

19 (a) (Date rec'd) 1947 (b) Huntington Williams Registrar

MAR VS-150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-28 1947, at 12:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-27 1947 to 2-28 1947, and that I last saw h[illegible] alive on 2-28 1947

Immediate cause of death Septicemia

| Duration |
|---|
| |
| |
| over |
| 5 weeks |

Due to Peritonitis

Due to Tubo-ovarian Abscess

Other Conditions Pelvic Abscess

(Include pregnancy within 3 months of death)

Date of operation 2-27-47

Major findings of operation: Pelvic Abscess

of autopsy: None

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. B. Harris / Physician M. D.

Address President Hospital Date signed 3-28-47

X

G49149

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 307

G49149 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs.) mos., or days) 43

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 145 W. Montgomery St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hate Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 42 | Months | Days | If less than one day hr. min.

9. Birthplace Gastonia NC (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Moore
13. Birthplace N. C

MOTHER
14. Maiden Name Laura Branch
15. Birthplace N. C

16 (a) Informant Lee River
(b) Address 2622 South Vein Pl

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Co
Location Balto City

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) (Date rec'd by registrar) (b) Registrar
MAR 3 - 1947 Huntington Hillsdale, Md

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 1947, at 12:25 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Hes death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Syphilitic aortitis Hypertrophy + acute dilatation of Heart; Acute pulmonary edema.

Due to Congestion of all viscera arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira, M.D. (Medical Examiner)
Date signed 3-26-47

PRESS WHITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5 0 3 8 7 G49150

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

128

Registered No. G49150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State N. C. (b) County
(c) City or town Greenville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 461 705 W 3rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Barry Grove

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | — |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-2-43

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 3 | 8 | 26 | hr. min. |

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name Vernon Grove
13. Birthplace N. C.

MOTHER
14. Maiden Name Dorin Lee
15. Birthplace N. C.

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 3 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location City

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (b) Huntington Williamson, M.D.
(Signature of registrar)
MAR 3 1947

VS 150

## MEDICAL CERTIFICATION

P

**20. DATE OF DEATH** Feb. 28 1947, at 6.23 M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Feb. 20 1947, to Feb 28 1947, and that I last saw him alive on Feb. 25 1947.

Immediate cause of death Pneumonia

Due to Cystic fibrosis of pancreas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

| Duration |
|---|
| |
| P |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23.** Signature George L Palmer

Address Harriet Lane Home Date signed 3-1-47 (M. D.)

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49151

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

46 B

G49151

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 811 N Monroe St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 811 N Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John O Roberts
3 (b) If veteran, name war: Spanish War
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | White | Married |

6 (b) Name of husband or wife Alice M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 68 | 7 | 13 | hr. min. |

9. Birthplace Baltimore City (Town, county, and state)
10. Usual Occupation Retired Letter Carrier
11. Industry or business

FATHER
12. Name Joseph D. Roberts
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Ann Rebecca Henry
15. Birthplace Baltimore Md

16 (a) Informant Alice M Roberts
(b) Address 811 N Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-3-47 (month) (day) (year)
(c) Cemetery or crematory New Bolt Natural Cemetery
Location Baltimore Md

18 (a) Funeral director Frank T Sealy
(b) Address 814 N 36 St.

19 (a) (Date rec'd by Registrar) (b) Washington Williams, Registrar

MAR 3 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 1947 at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Feb 27 1947.
and that I last saw h[illegible] alive on Feb 27 1947.

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Carcinoma stomach | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23, Signature J. Shorofsky M. D.
Address 601 N. Monroe St Date signed 2/28/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49152

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

Registered No. G49152

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1225 Linden Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 4
(d) Street No. 1225 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joan C van Hulsteyn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ruth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21. 1868

8. AGE: Years 78 | Months 3 | Days 11 | If less than one day hr. min.

9. Birthplace Amsterdam Holland (Town, county, and state)

10. Usual Occupation Musician

11. Industry or business Retired

FATHER 12. Name Maximilian van Hulsteyn

13. Birthplace Holland

MOTHER 14. Maiden Name Wilhelmina Fiske

15. Birthplace Holland

16 (a) Informant Ruth van Hulsteyn

(b) Address 1225 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/47 (month) (day) (year)

(c) Cemetery or crematory Farnon

Location Lutherville Md

18 (a) Funeral director Wilson & Son

(b) Address 1217 E Fort Ave

19 (a) Filed by registrar MAR 8 1947 Huntington Williams Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1947, at 6½ M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21, 1947 to 2 Mar 1947, and that I last saw h[illegible] alive on 1 March 1947

| Immediate cause of death | Duration |
|---|---|
| Coronary occlusion and myocardial infarction | 4 months |
| Due to Arteriosclerosis of the coronary arteries | |
| Due to | |
| Other Conditions — | |

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Andrew Arkulis M. D.

Address 1214 N. Caliber St Date signed 2 Mar 47

Retired

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49153

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

Registered No. G49153

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 723 Newington Ave.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) -

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County -
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 723 Newington Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Farnsworth

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Margaret E.
6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 4 | 18 | ___ hr. ___ min. |

9. Birthplace Formosa Ontario, Canada (Town, county, and state)
10. Usual Occupation Music Teacher
11. Industry or business Self

FATHER
12. Name Joseph Farnsworth
13. Birthplace Canada

MOTHER
14. Maiden Name Mary
15. Birthplace Canada

16 (a) Informant Mrs. Margaret E. Farnsworth
(b) Address 723 Newington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 3, 1947 (month) (day) (year)
(c) Cemetery or crematory Cematary
Location Moraland Mem. Park.

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) Mar 3 - 1947 (Date received by registrar) (b) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 28 1947, at 12 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945 to 2-28 1947. and that I last saw h[illegible] alive on 2-28 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary Occlusion | 1 hr. |
| Due to Coronary Sclerosis | 2 yr. |
| Due to Generalized Arterio-Sclerosis | 3 yr. |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Peterman Thomas M. D.
Address 2424 Eutaw Place Date signed 3-1-47

Huntington Williams, M.D.

X

G49154

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 51B

Registered No. G49154

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2808 Erdman Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2808 Erdmax Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Henry Pilert

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Lottie May Pilert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 7th 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | 5 | 24 | hr. min. |

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Oriental

FATHER
12. Name George Pilert
13. Birthplace Germany

MOTHER
14. Maiden Name Hannah
15. Birthplace "

16 (a) Informant Lottie May Pilert
(b) Address 2808 Erdman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) for Williams

MAR 5

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Mar 1st 1947; at 1:20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-6- 1946 to 3-1- 1947 and that I last saw him alive on 3-1- 1947

Immediate cause of death Cancer of Prostate — Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Nov. 19th 6

Major findings of operation: Cancer of prostate

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Milton C. Craig M. D.
Address 2117 Belair Date signed 3-1-47

X

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G49155 / 48a — Registered No. G49155

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Madison & Howard
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5204 Allendale Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Bertha M. Whiteway

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Widowed |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/2/1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 5 4 | 0 | hr. min. |

9. Birthplace Steubenville, Ohio (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name Edward Foner
13. Birthplace Ohio

MOTHER — 14. Maiden Name Annie Powell
15. Birthplace Ohio

16 (a) Informant Mrs. Dorothy Neilson
(b) Address 5204 Allendale Ave

17 (a) Burial (b) Date thereof 3/5/47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) (Date rec'd by reg.) MAR 3 1947 Huntington Williams, M.D.

VS MAR 3

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2 March 1947, at 8:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 11 1947 to March 2 1947 and that I last saw he alive on March 2 1947

| Immediate cause of death | Duration |
|---|---|
| Congestive Ht. Failure | |
| Due to Hypertensive C.V. Disease | |
| Due to | |
| Other Conditions Carcinoma of Cervix | |

(Include pregnancy within 3 months of death)

Date of operation Feb 13 1947

Major findings of operation: Ca of Cervix, Metastases to adnexa,

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Adolf Kellogg M.D.
Address Md. Gen. Hosp Date signed March 2, 1947

G49156

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1216

Reg. G49156

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) None

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Penna. (b) County York
(c) City or town New Freedom
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Dyer King

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | married |

6 (b) Name of husband or wife Josephine N. King
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1905

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 41 | 5 | 2 | hr. min. |

9. Birthplace Harford Co. Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Am. Insulation Corp.

FATHER
12. Name William A. King
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Cora Enfield
15. Birthplace Harford Co. Md.

16 (a) Informant Mrs Alberta Babington
(b) Address 1507 E. North Ave

17 (a) Burial (b) Date thereof 3/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Paul
Location Harford Co. Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) (Date rec'd by registrar) Huntington Williams, M.D.

MAR 3 1947

VS 189

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 2 1947 at 5:44 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 27 1947 to March 2 1947 and that I last saw him alive on March 1947

| Immediate cause of death | Duration |
|---|---|
| Uremia | |
| Due to Chronic Glomerulo-Nephritis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward F. Burkhart M. D.
Address Md. Gen. Hosp. Date signed March 3 '47

G49157

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

95B

Registered No. G49157

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4107 Frederick Ave.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) –

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4107 Frederick Ave. (If rural give location)
(e) Citizen of foreign country? n (Yes or No)
If yes, name country

**3 (a) FULL NAME** Anna Elizabeth Pilert

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| No | – |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife –
6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) March 3, 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 11 | 28 | ___ hr. ___ min. |

9. Birthplace – Unknown (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business –

**FATHER**
12. Name John J. Pilert
13. Birthplace Germany

**MOTHER**
14. Maiden Name C. H. Leimbach
15. Birthplace Germany

16 (a) Informant Christina Marie Pilert
(b) Address 4107 Frederick Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 3 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Burial

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) MAR 3 - 1947 (b) (Date rec'd by registrar) Huntington Hitchcock, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1947, at A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1941 to March 1947 and that I last saw h[er] alive on Feb 28 1947.

| Immediate cause of death | Duration |
|---|---|
| Bronchio-pneumonia | 3 Week |
| Due to | |
| Due to | |
| Other Conditions Rheumatic Heart Disease (Include pregnancy within 3 months of death) | |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 3821 Fred Ave Date signed 3/1/47

x

G49158 BALTIMORE CITY HEALTH DEPARTMENT G49158
Registered No.

# CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 W. Belvedere
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James J. Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband ~~Margaret~~ Cromwell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16th 1878

8. AGE: Years 68 | Months 7 | Days 12 | If less than one day hr. min.

9. Birthplace Texas
(Town, county, and state)

10. Usual Occupation Linotype Operator

11. Industry or business 20th Century

FATHER 12. Name Unknown Johnson

FATHER 13. Birthplace "

MOTHER 14. Maiden Name "

MOTHER 15. Birthplace "

16 (a) Informant Margaret Johnson

(b) Address 1303 W. Belvedere Ave

17 (a) Burial (b) Date thereof 3/3/47
(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Fort Lincoln

Location D. C.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

19 (a) MAR 3 1947
(Date rec'd by registrar) Huntington Registrar, M.D.

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2/28/47 19 at 5:45 p. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Dennis, M.D.
Medical Examiner.
Date signed 2/28/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G49159 X 131a

Registered No. G49159

G49159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Dukeland + Rayner Ave
(c) Hospital or institution:
West Balto Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 da
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto.
(c) City or town Halethorpe
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4321 Ridge Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frank B. Rice

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-8072

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | W |

6 (b) Name of husband or wife Laura Rice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Sept 5th 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 5 | 26 | hr. min. |

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Retired Machinist Foreman
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Nicholas Rice
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Barbara Wehner
15. Birthplace Balto. Md.

16 (a) Informant Frank B. Rice Jr.
(b) Address 4321 Ridge ave, Halethorpe Md

17 (a) Burial (b) Date thereof 3/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Grove
Location Portsmouth Va.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

19 (a) 9947 (b) Huntington Williams, M
(Date rec'd by registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 3-1 1947 at 2.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2-8 1947 to 3-1 1947, and that I last saw h. alive on 3/1 1947

| Immediate cause of death | Duration |
|---|---|
| Lobar Pneumonia | |
| Due to Uremia | |
| Due to Arteriosclerotic Cardio-Vascular Renal | |
| Other Conditions Diarrhea | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Same

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Berdansky M. D.
Address West Balto Gen'l Hosp Date signed 3/1/47

X

G49160

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH √171a

G49160 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) √ City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 14 E. Read Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Thomas H. Magness Sr. M. D.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | married |

6 (b) Name of husband or wife Julia Gertrude Mufarone
6 (c) If alive, give age 66 years
7. Birth date of deceased (mo., day, yr.) June 19 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 8 | 15 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name Henry F. Magness
13. Birthplace Harford Co., Md.

MOTHER
14. Maiden Name Laura A. Meyers
15. Birthplace Penna.

16 (a) Informant Thomas H. Magness Jr.
(b) Address 14 E. Read St.

17 (a) Burial (b) Date thereof 3/3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location North & Greenmount Ave.

18 (a) Funeral director W. W. E. Oppel's Sons
(b) Address Lombard & Asquith Sts.

19 (a) MAR 3 - 1947 (Registered by registrar) Williams
Registrar

VS 181

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/28 1947, at 6:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of Cervical vertebra
Crushed chest
Due to Multiple fractures, including base of skull.
Other Conditions Lacerations, bruised brain, abrasions & contusion of trunk.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2/28/47 at 5 P.M. 11/2
(b) Where did injury occur? In front of 14 E. Read St
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? —
(d) Means of injury Pedestrian struck by streetcar

23. Signature Thomas J. Wessels M.D.
Medical Examiner.
Date signed 3/1/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49161

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1163 B

Reg. No. G49161

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26a
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2104 E. Pratt Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John B. Opdyke

3 (b) If veteran, name war No

3 (c) Social Security Account No. 227-14-3710

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: (March 9, 1920)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 26 | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace Hampton, Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business American Radiator

FATHER
12. Name John B. Opdyke
13. Birthplace Washington, D.C.

MOTHER
14. Maiden Name Lillian Olsen
15. Birthplace Newport News, Va.

16 (a) Informant Lillian Olsen
(b) Address 246 Spring Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. end of North Ave.

18 (a) Funeral director H. W. E. Oppold & Sons
(b) Address Harford & Erdman Sts.

19 (a) (Date received by registrar) MAR 3 1947 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 1947, at 3:46 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Barbiturate poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-26-47 at ? M.
(b) Where did injury occur? 2104 E. Pratt Street
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Ingestion of Seconal Tablets

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 3-1-47

VS 151

G49162

BCH D68778

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 182a

G49162 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1141 Argyle Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1141 Argyle Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Thorton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, ~~married, widowed,~~ or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 19, 1947

8. AGE: Years | Months | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Frank Thorton

13. Birthplace Virginia

MOTHER 14. Maiden Name Georgia Banks

15. Birthplace Virginia

16 (a) Informant Dr. A. Lee Ellis

(b) Address 924 Madison Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School FEB 28 1947

18 (a) Funeral director Commissioner of Health

(b) Address

MAR 3 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 181

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 1947, at 2 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Mechanical suffocation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 17/2

(a) Date of injury 2/13/47 at about 6 a.m.

(b) Where did injury occur? 1141 Argyle Ave

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury by Hanging & Strangulation

23. Signature [illegible] M.D. Medical Examiner.

Date signed 2-13-47

X

G49163

BC# 369570

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 106a

G49163

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2431 Pasa at
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Louise James

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/29/47

8. AGE: Years | Months | Days: 12 | If less than one day: hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name
13. Birthplace Unknown

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School FEB 28 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 3 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 151

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 2/28 1947, at 10 A.M.

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Adrenal hemorrhage.
Bronchitis
Due to

Other Conditions
(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

**23.** Signature George G. Merrill M.D.
Medical Examiner.
Date signed 3/11/47

G29164

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G29164

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1019 Webb Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1019 Webb Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Monroe J. Henderson

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 214-03-7123

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 2 | 24 | hr. min. |

9. Birthplace Alabama (Town, county and state)
10. Usual Occupation Helper
11. Industry or business Balto Dry Dock Ry Co

FATHER
12. Name John Henderson
13. Birthplace Alabama

MOTHER
14. Maiden Name Lemara McGray
15. Birthplace Alabama

16 (a) Informant Mrs. Margie E. Henderson
(b) Address 1019 Webb Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 3rd 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd

18 (a) Funeral director Elmer W. Confessionem
(b) Address 824 E. Eager St.
(c) MAR 3 - 1947 (Date rec'd by registrar) Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Mar 1 1947, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/24 1947 to 3/1/47 1947, and that I last saw h[illegible] alive on 2/24 1947

| Immediate cause of death | Duration |
|---|---|
| Acute Coronary infarction | |
| Due to Chronic Sclerosis | |
| Due to Coron Sclerosis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. G. Hornstein M. D.
Address 733 Airport St Date signed 3/3/47

VS 150

G49165

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 102

Registered No. G49165

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2730 N Howard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Roth

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | M |

6 (b) Name of husband or wife Harry F Roth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 7 | 19 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Charles Rohleder
13. Birthplace Maryland

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Harry Roth
(b) Address 2720 N Howard St

17 (a) Burial (b) Date thereof 3-4-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Jos D Stegmaier Son
(b) Address 3011 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

MAR 5 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 1947, at 1:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-28 1947 to 3-1 1947; and that I last saw her alive on March 1 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure | |
| Due to Hypertension | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward P. Smith M.D.
M. D.
Address Mercy Hospital Date signed 3-1-47

X

G49166

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G49166

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2473 Cold Spring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2473 Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Samuel Goldstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years 43 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Printer

11. Industry or business

FATHER 12. Name Benjamin
13. Birthplace Poland

MOTHER 14. Maiden Name Blaugbe
15. Birthplace Poland

16 (a) Informant Mina Goldstein
(b) Address 2473 Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-3-47 (month) (day) (year)

(c) Cemetery or crematory Rodell
Location Pikesville

18 (a) Funeral director Jack Lemmler
(b) Address 1439 E. Baltimore St

19 (a) MAR 3 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 3-1-1947 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 27, 1947 to March 1, 1947. and that I last saw him alive on March 1, 1947.

Immediate cause of death: Coronary occlusion, acute — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis R. Mazer M.D.
Address 4327 Park Heights Ave Date signed 3-2-47 M. D.

X

G49167

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1178

Registered No. G49167

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 586 S Belair Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** HARRY F. ROTHAUS

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | widowed |

6 (b) Name of husband or wife Anna Marie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29 1894

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 7 | 27 | hr. min. |

9. Birthplace ? (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Miss Margaret Rothaus
(b) Address 5860 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/3/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 MAR 2 - 1947 (Date rec'd by registrar) (Signature) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH February 26 1947, at 3 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute peritonitis from ruptured ulcer of duodenum

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 2/27/47

VS 181

G49168

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

47c

Registered No. G49168

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) less than 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) less than 1 day

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Del. (b) County
(c) City or town Bowers (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Young, Harry Turner

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | White | Widower |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 10 | 9 | hr. min. |

9. Birthplace Philadelphia, Pa. (Town, county, and state)
10. Usual Occupation Deckhand
11. Industry or business Seafarer

FATHER
12. Name Benjamin Young
13. Birthplace Philadelphia, Pa.

MOTHER
14. Maiden Name Sallie Turner
15. Birthplace Philadelphia, Pa.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar- 3/47 (month) (day) (year)
(c) Cemetery or crematory [illegible]
Location York Road

18 (a) Funeral director Odell Funeral Home Inc
(b) Address 403 E 25th St

19 MAR 3 - 1947 (b) Huntington Williams, M.D. Registrar
Date rec'd by registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1947, at 10:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 27 1947, to Feb. 28 1947, and that I last saw him alive on Feb. 28 1947.

Immediate cause of death
Carcinoma, probably bronchogenic with metastases to liver, kidney, and adrenal — Duration: Unknown
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert C. Dunn, O.D.
Address U.S. Marine Hospital Date signed 3/28/47 M. D.

VS 150

G49169

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V 61

G49169 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3522 Edmondson Ave.
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3522 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel George Kugler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife (nee Hartlove) Late Emma F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1873.

8. AGE: 75 Years | 4 Months | 23 Days | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Sheet Metal Business

FATHER
12. Name Thomas H. Kugler
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Mrs. Eldridge P. Burns
(b) Address 3522 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch. 3/47.
(month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Kubsch
(b) Address 4101 Edmondson Ave.

MAR (c) Date rec'd by registrar 1947 Huntington Williams M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1947; at 7 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from 1/1 1935 to 2/28 1947, and that I last saw him alive on 2/28 1947.

| Immediate cause of death | Duration |
|---|---|
| cardiac failure | 2 hrs. |
| Due to generalized arteriosclerosis | 15 yrs. |
| Due to | |
| Other Conditions cerebral hemorrhage diabetes mellitus (Include pregnancy within 3 months of death) | 1 day 10 yrs. |

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George H. Kupp M. D.
Address 3820 Edmondson Ave. Date signed 3/4/47

97

G49170

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G49170 Registered No. 124 B

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 30 N. Linwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 30 N. Linwood Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Edna Lavinia Bettini

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband David Joseph Bettini
6 (c) If alive, give age 47 years
7. Birth date of deceased (mo., day, yr.) July 31 1899
8. AGE: Years 47 Months 7 Days 2 If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business none

FATHER
12. Name Frederick J. Rau
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary E. Miller
15. Birthplace Baltimore

16 (a) Informant David Bettini
(b) Address 30 N. Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 6/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Taylor Ave
18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.
19 (a) MAR 3 1947 (Registrar) Huntingtown Williams, Md. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 2 1947, at 1215 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 1946 to March 2 1947, and that I last saw h.e.r alive on March 2 1947.

| | Duration |
|---|---|
| Immediate cause of death: Pulmonary embolism | 5 hr. |
| Due to: Thrombophlebitis left. | 3 days |
| Due to: Anemia — [redacted] | — |
| Other Conditions: Cirrhosis of liver | 5 mos. |

(Include pregnancy within 3 months of death)
Date of operation November 1946
Major findings of operations: negative Exploratory laparotomy
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature James K. Dooley Jr M.D.
Address 2936 E. Baltimore Date signed 3/4/47

PLEASE WRITE PLAINLY, with indelible pencil. Do not use crayon. Do not write above or below the lines. Be sure to write the causes of death clearly and legibly. Do not abbreviate. Do not use ditto marks. Be sure to answer every question. If unknown, state so. Do not leave blanks. Be sure to write the correct age in each case. If less than one day, give hours or minutes. If one day and less than one year, give days. If one year and less than five years, give years and months. Otherwise give years only. The space for "Length of stay in Baltimore" is especially important. Physicians: please write the causes of death clearly and legibly.

VS 2

G49171

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 186a

Registered No. G49171

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 78

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 732 E. Biddle (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John. H. Fischer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: wh.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1869

8. AGE: Years 78 | Months 2 1 | Days 21 0 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation retired Laborer

11. Industry or business Pa. R.R.

FATHER
12. Name John Fischer
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Yeakel
15. Birthplace Germany

16 (a) Informant Hosp. Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/47 (month) (day) (year)
(c) Cemetery or crematory Balto. Md.
Location

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (Date received by registrar) MAR 3 - 1947 Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Mar. 2 1947 at 6 50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-21 1947 to 3-2 1947 and that I last saw him alive on 3-2- 1947

| | Duration |
|---|---|
| Immediate cause of death: resp. failure | 12 da |
| Due to: heart failure | |
| Due to: hypostatic pneumonia | |
| Other Conditions: fracture femur | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 10/1
(a) Accident, suicide, or homicide accidents
(b) Date of occurrence 2-20-47 at 2 P M
(c) Where did injury occur? 732 E. Biddle (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? no (Specify type of place)
(e) Means of injury Slipping + fell down steps

23. Signature Jules Turlach M. D.
Address Mercy Hosp. Date signed 3-2-47

Approved by C. A. Schmuck M.D. X

VS 150

G49172

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G49172 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland Bentalou St
(b) Street address 432 Bentalou St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Y
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto city (If outside city or town limits, write RURAL after name of town)
(d) Street No. 432 S Bentalou St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Annie Pauline Wade

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F M

5. Color or race W

6 (a) Single, ~~married~~, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 31 — 1890

8. AGE: Years 56 Months 6 Days 21 If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Julius Traugott

13. Birthplace Germany

MOTHER 14. Maiden Name Pauline

15. Birthplace Germany

16 (a) Informant Jane Wade 432 S. Bentalou St

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 / 5 - 47 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem

Location Eastern ave

18 (a) Funeral director Edward Tonfson

(b) Address 2317 Wash blvd

19 (a) 1947 (b) Date rec'd (Registrar)

MAR 5

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 2 1947, at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1946, to Mar 2 1947, and that I last saw her alive on 2 Mar 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary Occlusion | 1 hr |
| Due to Arteriosclerotic C-V Disease | |
| Due to Chronic Nephritis | |
| Other Conditions diabetes, cirrhosis of liver, | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H S Baylus M. D.

Address 1600 Millington Ave Date signed 3/3/47

131 B

G49173

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 837

G49173 Registered No.

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1235 E. Monument St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 1 24
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1235 E Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A. Douglas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Bettie Douglas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Jamaica East India (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Roland Douglas
13. Birthplace Jamaica East India

MOTHER
14. Maiden Name Annie ?
15. Birthplace Jamaica East India

16 (a) Informant Bettie Douglas
(b) Address 1235 E Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 (month) 5 (day) 47 (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy A Wilson
(b) Address 1000 Eastern Ave

19 (a) (Date received by Registrar) MAR 5 1947 (b) Registrar

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28 1947, at 10:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1947 to Feb 28 1947 and that I last saw him alive on Feb 25 1947

| Immediate cause of death | Duration |
|---|---|
| Hypostatic pneumonia | 10 days |
| Due to Hemiplegia | 16 mos. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. W. McDaniel M. D.
Address 807 N. Caroline St Date signed 3-3-47

Huntington Ave

G19174

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G19174
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 302 W Lexington St.
(c) Hospital or institution: Fayette Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Howard Elkton
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Main Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary J. Beck

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John Beck
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 9, 1855

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 92 | — | 21 | hr. min. |

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

**FATHER**
12. Name: John L. Krager
13. Birthplace: Baltimore, Md.

**MOTHER**
14. Maiden Name: Sarah Hemline
15. Birthplace: Maryland

16 (a) Informant: Mrs. Blanche V. Kerger
(b) Address: Ellicott City, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar. 4 1947 (month) (day) (year)
(c) Cemetery or crematory: Western Cem.
Location: Edmondson Ave. Balto.

18 (a) Funeral director: Easton Home
(b) Address: Ellicott City, Md.

MAR 3 - 1947 (Date rec'd by local registrar) Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 2, 1947 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 28 1947 to March 2 1947 and that I last saw h[er] alive on March 2 1947

| Immediate cause of death | Duration |
|---|---|
| Primal Carcinoma Adenocarcinoma | 8 yrs |
| Chronic Myocarditis | 10 yrs |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Ralph L. Solomon
Address 129 S. Broadway Date signed 3/3/47

VS 150

# NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G49175 Malissa Rawlings

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93E

G49175 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 659 Harford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 659 Harford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Malissa Rawlings

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | Col | Widow |

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-22-1864

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 1 | 6 | hr. min. |

9. Birthplace (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

| | |
|---|---|
| FATHER | 12. Name Lewis Parker |
| | 13. Birthplace Va. |
| MOTHER | 14. Maiden Name Harriet Jones |
| | 15. Birthplace Va. |

16 (a) Informant Lucille Pitt
(b) Address 11 West Ave Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location

18 (a) Funeral director Wm Pat Gill & Co
(b) Address 1247 N. Eastern Ave

19 (a) 1941 (Date rec'd by registrar) (b) Jos Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2-28 1947, at 12:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-27 1947 to 2-28 1947 and that I last saw her alive on 2-28 1947

| Immediate cause of death | Duration |
|---|---|
| Acute Dilatation of Heart | 1 Hour |
| Due to Acute Indigestion | 1 Day |
| Due to | |
| Other Conditions Neuritis | 2 Years. |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. F. Berry M.D.
Address 1420 E. Chase Date signed 3-5-47

VS 150

G19176

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G19176

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1134 Battery Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 4
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1134 Battery ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Agatha Lorenz

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife John A. Lorenz
6 (c) If alive, give age 89 years

7. Birth date of deceased (mo., day, yr.) June 9-1860

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 86 | 8 | 19 | 2 hr. min. |

9. Birthplace Switzerland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Andrew Siegwart
13. Birthplace Switzerland

MOTHER
14. Maiden Name Carecentia
15. Birthplace Switzerland

16 (a) Informant Miss Marie Lorenz
(b) Address 1134 Battery ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 4-47 (month) (day) (year)
(c) Cemetery or ~~cemetery~~ Holy Redeemer
Location Belair Road

18 (a) Funeral director Elizabeth Hardt Sons
(b) Address 115 E. West St.

19 (a) MAR 3 - 1947 (Date rec'd by registrar) (b) [illegible] for Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 1st 1947 8:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15 1945 to 3/1 1947 and that I last saw he alive on 2/28 1947

| Immediate cause of death | Duration |
|---|---|
| General arteriosclerosis - chronic | 2 |
| Due to myocarditis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Leiter M.D.
Address 226 Hanover St. Date signed 3/3/47

VS 190

G491177

4144 66

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 848

Registered No. G491177

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 948 Franklintown Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Harry D. Eastman

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-10-19

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 27 | 4 | 23 | hr. min. |

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harry D. Eastman
13. Birthplace Md

MOTHER
14. Maiden Name Edna Bailey
15. Birthplace Md

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch 4 47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemy
Location Gwynn Oak Ave

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eastern Place

3-(a) 1947 (Date rec'd by registrar) (b) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 2 1947, at 6 29 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-27 1947, to 3-2 1947, and that I last saw him alive on 3-2 1947.

Immediate cause of death Post operative hemorrhage (Internal) — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration over

(Include pregnancy within 3 months of death)

Date of operation 3-1-47.

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. W. Burkland M. D.
Address J. H. H. Date signed 3-2-47

X

G49178

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

112

G49178
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5728 Pennington Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5728 Pennington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** GEORGE CHARLES ALTEVOGT

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife: Viola M. Altvogt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 12, 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 0 | 19 | hr. min. |

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual Occupation: none
11. Industry or business

FATHER
12. Name: Henry Altevogt
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Mary Noye
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. Viola M. Altevogt
(b) Address: 5728 Pennington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/47 (month) (day) (year)
(c) Cemetery or crematory: Oaklawn Cem.
Location: Balto. Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) [illegible] Williams, M.D. Registrar
(Date rec'd by registrar)

AR B -vs- 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 1, 1947, at 4:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Feb 26 1947
and that I last saw h[illegible] alive on Feb 26 1947
Immediate cause of death: 1
Hypertrophy of Ventricle
Due to Bronchial Asthma
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Operation: Organic Heart Failure

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Peter A Harlow M. D.
Address 5720 Pennington Ave Date signed 3/4/47

X

G49179

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. Ba G49179

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3512 N. Calvert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3512 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** ROSE E. BANKS

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | no |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widow |

6 (b) Name of husband or wife Charles W. S. Banks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1853

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 93 | 4 | 16 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Stromenger
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Erdman
15. Birthplace Md.

16 (a) Informant Mr. Walter H. Stromenger
(b) Address 3512 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 3 1947 (Date received by registrar) (b) Huntington Williams (Signature of registrar)

VS 189

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1st March 1947 at 11:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 27 Feb 1947 to 1 Mar 1947, and that I last saw her alive on 1 Mar 1947.

Immediate cause of death Acute Myocardial failure — Duration Years 3

Due to Arteriosclerotic C.V. disease —

Due to Auricular fibrillation —

Other Conditions Senility.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. E. Muse Jr.
Address 331 N St. Paul St Date signed 3/1/47

PLEASE WRITE PLAINLY, WITH UNFADING INK: Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49180

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93

G49180 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3412 Elgin Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3412 Elgin Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** LOTTIE VIRGINIA WATHEN

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widow |

6 (b) Name of husband or wife Robert Duke Wathen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1858

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 88 | 10 | 20 | hr. min. |

9. Birthplace Norfolk, Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. H. Etheridge
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Virginia Freeman
15. Birthplace Virginia

16 (a) Informant Mr. R. B. Wathen, son
(b) Address 3705 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 1947 (Date filed by registrar) (b) Registrar

Purchaser Illegible

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 1, 1947, at 3:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15, 1947 to Mar. 1, 1947. and that I last saw her alive on Mar. 1, 1947.

| Immediate cause of death | Duration |
|---|---|
| Myocarditis about | 1 mo. |
| Acute heart failure | 1 day |
| Due to Advanced arteriosclerosis- ? | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Tublet M. D.
Address 2222 Garrison Blvd. Date signed 3-5-47

X

G49181 ✓ G49181

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 186a

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd Street.
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs 10 mos

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2411 Kenesk Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** ALICE A. THOMAS

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced: |
|---|---|---|
| F | W | ? |

6 (b) Name of husband or wife Edward F. Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 28, 1845

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 101 | 6 | 4 | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Jacob Kurtz
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Winter
15. Birthplace Philadelphia, Pa.

16 (a) Informant Son. MR. Christian H. Thomas
(b) Address 2411 Kenesk Rd. Mt Washington

17 (a) Burial (b) Date thereof 3/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 3 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 2nd 1947; at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1947 to March 2nd 1947, and that I last saw her alive on March 2nd 1947.

| Immediate cause of death | Duration |
|---|---|
| Respiratory Failure. | |
| Due to Fracture of Left Femur. | |
| Due to | |
| Other Conditions Fracture of Knee | 11 da. |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations —
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident 2/15
(b) Date of occurrence March 15 at P.M.
(c) Where did injury occur? 2411 Kenesk Rd. Mt. Washington Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home. While at work? —
(Specify type of place)
(e) Means of injury: Fell — struck by floor

23. Signature [illegible] M.D.
Address Union Memorial Hosp. Date signed March 7
For C. J. R. Davis, by Howard J. Mallonee, M.D.

VS 150

G49182

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No. G49182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3131 Belmont Ave.
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3131 Belmont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** (ANNIE) ANNE M. LAUGHLIN

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widow |

6 (b) Name of husband or wife John J. Laughlin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 5 | 16 | hr. min. |

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William O'Brien
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah Mulleney
15. Birthplace Ireland

16 (a) Informant Mrs. Nora A. Harrington
(b) Address 3131 Belmont Ave.

17 (a) Burial (b) Date thereof 3/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

(a) MAR 3 1947 (b) Registrar
(Date rec'd by Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 1, 1947, at 7:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 28 1947 to Mar 1 1947. and that I last saw her alive on Feb 28 1947

Immediate cause of death: Coronary Occlusion — Duration: 1 day

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: none
of autopsy: none

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at ✓ M
(c) Where did injury occur? ✓
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? ✓
(Specify type of place)
(e) Means of injury ✓

23. Signature Howard J. Bruns, M.D.
Address 2219 Eastlake Terrace Date signed 3/3/47

VS 150

G49183 BCH #58781

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

108

Registered No. G49183

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert
(c) Hospital or institution: Union Memorial Hospital 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 mos.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Allen Cleary

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 9, 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 0 | 4 | 24 23 | hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Frank Cleary
13. Birthplace Texas

MOTHER
14. Maiden Name Martha Taylor
15. Birthplace Kentucky

16 (a) Informant Mother
(b) Address ?

17 (a) Burial (b) Date thereof Mar. 5, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Hampden

18 (a) Funeral director C. Kenneth O'Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) MAR 3 - 1947 Huntington Williams M.D.
(Date received by Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1947; at 11:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 28 1947 to March 1 1947 and that I last saw him alive on March 1 1947

Immediate cause of death: Respiratory failure — Duration 15 min.
Due to: Lobar pneumonia (R upper + left lower lobes) — 4 days
Due to:
Other Conditions: Diarrhea
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Whitmeister Turnbull, Jr. M.D.
Address Union Mem. Hospital Date signed 3-2-47

VS 150

G49184 BC# F88/68

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. G49184

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1426 Hanover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carolyn Montgomery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1943

8. AGE: Years 3 | Months 4 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Walter Montgomery
13. Birthplace Kentucky

MOTHER
14. Maiden Name Eula E. Caskey
15. Birthplace Kentucky

16 (a) Informant Walter Montgomery (Father)
(b) Address 1426 Hanover St

17 (a) Burial (b) Date thereof 3/6/1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Ashland Cemetery
Location Ashland, Kentucky

18 (a) Funeral director Fred A. Krauss & Son
(b) Address 1216 E. Chase St.

19 (a) (b)
(Primary registration) (District) (Registrar)

MAR 3 1947 Huntington Baltimore, Md.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3rd 1947 at 4:55 P M

21. I certify that I took charge of the remains described above, held an Aug & Insp thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Burn, 2nd Degree of 50% of body area

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2 March 1947 9:50 P M
(b) Where did injury occur? 1426 Hanover St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Clothing Caught Fire from Open Fire.

23. Signature William G. Hoffacker M.D.
Medical Examiner.
Date signed March 3, 1947

X

G49185

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 92 c

G49185 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2150 Boston Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore 31 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2150 Boston Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Elizabeth Furman

3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov, 19-1879
8. AGE: Years 67 | Months 3 | Days 11 | If less than one day hr. min. 1/3
9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Wikarski
13. Birthplace Poland

MOTHER
14. Maiden Name Magdalena ?
15. Birthplace Poland.

16 (a) Informant Frances Furman
(b) Address 2150 Boston Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Of Mary
Location Baltimore County, Md.
18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street
19 (a) (Date rec'd by registrar) (b) Registrar

MAR 3 - 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 2nd 1947, at 4.15 P. M.
21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1 19 46 to March 2 19 47 and that I last saw h[illegible] alive on March 2 19 47.

Immediate cause of death: Cardiac decompensation — Duration 6 mos.
Due to: Chr. Endocarditis & Myocarditis — 7
Due to: Ch. Hypertension —
Other Conditions: Surgical Menopause 2 mos.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 200 W. Fayette Date signed 3/3/1947

G49186

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46F

G49186

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 225 S. Washington Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore-31 (If outside city or town limits, write RURAL and give town)
(d) Street No. 225 S. Washington Street (If rural give location)
(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** Sophia Gruntowicz

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband ~~XXXXX~~ Joseph
6 (c) If alive, give age deceased years

7. Birth date of deceased (mo., day, yr.) Feb, 2nd-1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | - | 27 | hr. min. |

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Anthony Imielinski
13. Birthplace Poland

MOTHER
14. Maiden Name Katherine ?
15. Birthplace Poland.

16 (a) Informant Margaret Gruntowicz
(b) Address 225 S. Washington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-4-47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar
MAR 3 - 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 1st 1947, at 3:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1947, to 3/1 1947, and that I last saw her alive on 3/1 1947

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of liver | Months |
| Due to | |
| Due to acute | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations X
Of autopsy none

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature A. C. Kaan M. D.
Address 7901 Eastern Ave. Date signed 3/4/47

X

G49187

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G49187 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 817 S. Lakewood Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore-24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 S. Lakewood Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME: Stanislaus L. Olszewski Or James Olszewski

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-07-2575

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of wife: Katherine
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) May 25-1893

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | 9 | 4 7 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Michael Olszewski
13. Birthplace Poland

MOTHER
14. Maiden Name Michalena Sadowski
15. Birthplace Poland.

16 (a) Informant Mrs. Katherine Olszewski
(b) Address 817 S. Lakewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street

19 (a) (Date rec'd by registrar) (b) Registrar

VS 8 MAR 3 - 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 1st 1947, at 3.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1/46 19 to 3/1/47 19; and that I last saw alive on 3/1/47 19.

Immediate cause of death: Coronary Occlusion — Duration 1 hr.
Due to Coronary Thrombosis — 6 mo
Due to
Other Conditions none
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. T. Harrington M. D.
Address 1710 E 33 Date signed 3/7/47

G49188

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 93D

Registered No. G49188

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1734 Gorsuch Ave
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1734 Gorsuch Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Elizabeth J. Carroll

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed or divorced |
|---|---|---|
| F. | W. | Widow |

6 (b) Name of husband or wife Late T. Carroll
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 27 1863

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | - | 1 | hr. min. |

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Robert French
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Ellen Lynch
15. Birthplace Washington D.C.

16 (a) Informant Bernard J. Carroll
(b) Address 5296 38th St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3/4/47 (month) (day) (year)
(c) Cemetery or crematory St Johns Cemetery
Location Long Green

18 (a) Funeral director Charles H. Logan
(b) Address 3000 E Baltimore St

19 (a) (Date rec'd by registrar) (b) Filed for Williams, M.D. Registrar

VS MAR 3 - 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 28 1947, at 11:2[illegible] A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1946 to Feb 28 1947 and that I last saw h[illegible] alive on Feb 28 1947

Immediate cause of death Coronary Thrombosis — Duration 2/28/47
Due to Arterio Sclerosis — Duration 1941
Due to — Duration
Other Conditions — Duration
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Rayner M.D.
Address 801 N Eutaw St Date signed 3/3/47

G49189

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 467

Registered No. G49189

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 128 N Lanzerne Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 128 N Lanzerne Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Martin Stadter

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or ~~wife~~ Katie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 11 | 8 | hr. min. |

9. Birthplace Germany
(Town, county and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name George Stadter
13. Birthplace Germany

MOTHER
14. Maiden Name Winkler
15. Birthplace Germany

16 (a) Informant John M. Stadter
(b) Address 128 N Lanzerne Ave

17 (a) Burial (b) Date thereof 3/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director John C. Molyneaux
(b) Address 3000 E Baltimore St

19 (a) (b) Registrar
(Date rec'd by registrar)

MAR 3 1947

V S 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 22 1947 to Feb 28 1947, and that I last saw h. alive on Feb 28 1947.

| Immediate cause of death | Duration |
|---|---|
| Heart Failure | 2 days |
| Due to Carcinoma Kidney with metastasis Bladder | 2½ years |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. L. Meagher M.D.
Address 1601 E Belvedere Date signed 3/4/47

X

G49190 BALTIMORE CITY HEALTH DEPARTMENT G49190

Philippine Gotzian CERTIFICATE OF DEATH 46E Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43 days
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3901 Greenmount ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Philipine Gotzian

3 (b) If veteran, name war Civil Service | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widowed |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 · 14 · 1864

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | 10 | 16 17 | hr. min. |

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER
12. Name Frederick Konrad
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Lehmel
15. Birthplace Germany

16 (a) Informant H. Johnson
(b) Address overland ave Balt.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 4/47 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel Cem
Location Arnold Road
18 (a) Funeral director John L Moran
(b) Address 3000 E Baltimore St
19 (a) (Date received by registrar) (b) Huntington Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1947 at 2:40 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1947 to March 1 1947 and that I last saw h as alive on 2-28 1947
Immediate cause of death Circulatory failure | Duration
Due to Carcinoma of colon
Due to
Other Conditions Cystitis + pyelonephritis.
(Include pregnancy within 3 months of death)
Date of operation 11-17-46 & 2-12-47
Major findings of operation: Carcinoma growth obstructing the canal
Was there autopsy? Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Richard L Martin M. D.
Address Maryland Gen. Hosp. Date signed 3-1-47

VS 150

G49191

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 54a

Registered No. G49191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. 6 (If outside city or town limits, write RURAL and give town)
(d) Street No. 4419 Mannasota Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Alvado Muth

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | M |

6 (b) Name of husband or wife John A. Muth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12-1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 0 | 18 | hr. min. |

9. Birthplace Geo Co (Town, county and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Rufus Spence
13. Birthplace Georgia

MOTHER
14. Maiden Name Emilia ?
15. Birthplace Georgia

16 (a) Informant Mrs. John A. Muth
(b) Address 4419 Mannasota Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS MAR 3

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 3-2 1947 at 1:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-27 1947 to 3-2 1947 and that I last saw he alive on 3-1 1947.

| Immediate cause of death | Duration |
|---|---|
| Medullary failure | |
| Due to Adenocystoma Left Ovaula | |
| Due to INSUIA | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. C. Blackwell Jr. M. D.
Address University Hospital Date signed 3-4-47

X

Dr. Hirschfeld
6919 Harford Road

G49192

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 48a

Registered No. G49192

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2913 Bauernwood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2913 Bauernwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Marie Anna Hevell

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| fmela | white | married |

6 (b) Name of husband or wife William Hevell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 1 | 1 4 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ? Eff
13. Birthplace ?

MOTHER
14. Maiden Name ? Storke
15. Birthplace ?

16 (a) Informant Mr. William Hevell
(b) Address 2913 Bauernwood Avenue

17 (a) Burial (b) Date thereof 3/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ~~Parkwood~~ Moreland P.K.
Location Baltimore

18 (a) Funeral director Leonard J. Buck
(b) Address 5305 Harford Road ,-14-

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 MAR 3 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 2nd, 1947 at 9:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/7 1946, to 3/2 1947, and that I last saw HER alive on 3/2 1947.

| Immediate cause of death | Duration |
|---|---|
| UREMIA | 3 days |
| CARCINOMA OF CERVIX | 17 YEARS |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John H. Hirschfeld M.D.
Address 6919 Harford Rd Date signed 3/3/1947

Tentative Williams, M.D.

Dr. Jacob G49193
1700 Eutaw Place

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 94a

G49193 Registered No.

Every item of information should be carefully supplied. The... write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Mercy Theime
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3022 Kayser Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Mary C Thieme THIEME

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | M |

6 (b) Name of husband or wife August F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 6 | 14 | hr. min. |

9. Birthplace Balto - Md (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER 12. Name Schmidt
FATHER 13. Birthplace
MOTHER 14. Maiden Name
MOTHER 15. Birthplace

16 (a) Informant Mrs. Hilda Doerfler
(b) Address 3022 Kayser Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto
18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Rd.
19 (a) MAR 3 1947 (Date received by registrar) (b) Morgan Williams Registrar

VS 190

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** March 1 - 1947, at 7:55 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1947 to March 1 1947, and that I last saw h[illegible] alive on March 1 - 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | |
| Due to Adv. Atherosclerosis | |
| Due to | |
| Other Conditions Chr. Bronchitis & Emphysema | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23. Signature** Louis Jacob M. D.
Address 1700 Eutaw Pl. Date signed 3-2-47

X

G49194

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

G49194 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Lafayette + John Sts.
(c) Hospital or institution: Womens Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 da.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore - 25 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1052 Jack Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Wharren "B" (a twin)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1947

8. AGE: Years | Months | Days | If less than one day: 1 hr. 6 min.

9. Birthplace Baltimore City, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Gordon Henry Wharren
13. Birthplace Curtis Bay, Maryland

MOTHER
14. Maiden Name Mayme Viola Poland
15. Birthplace Skelton, West Virginia

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 MAR 3 1947 (Date rec'd by Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 1947, at 8 36 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 28 1947 to Feb. 28 1947 and that I last saw him alive on Feb. 28 1947

Immediate cause of death: Respiratory failure
Prematurity - 28 wks.

| | Duration |
|---|---|
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James N. McCool M. D.
Address Womens Hospital Date signed 2/28/47

Johns Hopkins Medical School MAR 3 1947 Commissioner of Health

VS 2

G49195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G49195 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & Johns Sts
(c) Hospital or institution: Womens Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 25
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1052 Jack Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Wharren "A" (a twin)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1947

8. AGE: Years | Months | Days | If less than one day: 0 hr. 30 min.

9. Birthplace Baltimore City, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Gordon Henry Wharren
13. Birthplace Curtis Bay, Maryland

MOTHER
14. Maiden Name Mayme Viola Polland
15. Birthplace Skelton, West Virginia

16 (a) Informant Hospital records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 3 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 3 1947 (Date rec'd by registrar) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 1947 at 8 36/A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 28 1947 to Feb 28 1947 and that I last saw h alive on Feb 28 1947.

| | Duration |
|---|---|
| Immediate cause of death: Respiratory Failure | 30 min |
| Due to: Prematurity | 28 wks |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James N. McCord M.D.
Address Womens Hospital Date signed 3/2/47

VS 3

G49196 Birth Certificate G-73654

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

161a

G49196 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) one
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: NEW BORN
(a) State (b) County Baltimore
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Franklin Square Hosp. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy Vopalecky Twin-19 Triplet Number 4th Child

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/28/47

8. AGE: Years | Months | Days | If less than one day 5 hr. 17 min.

9. Birthplace Franklin Sq. Hosp Balto Md. (Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business

FATHER
12. Name Charles F Vopalecky
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name DOROTHEA Vopalecky
15. Birthplace Balto. Maryland

16 (a) Informant DOROTHEA VOPALEKY
(b) Address 3604 FAIRE UNION PARK Rd.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 3 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 3 1947 (Date rec'd by registrar) Wilmington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 March 1947, at 1 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/28 1947 to 3/1 1947 and that I last saw him alive on 3/1 1947

Immediate cause of death Respiratory failure — Duration

Due to Atelectasis & Newborn

Due to Prematurity

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: Atelectasis -

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Franklin Sq. Hosp. Date signed 3/1/47

VS 150

G43197 B.C.G.-12195

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

160a

Registered No. G43197

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 81 Calvert Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pinckney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 27, 1947

8. AGE: Years | Months | Days | If less than one day: 15 hr. 10 min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Walter Pinckney
13. Birthplace

MOTHER
14. Maiden Name: Caroline Parker
15. Birthplace: Maryland

16 (a) Informant: Hospital Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location: Johns Hopkins Medical School MAR 3 1947

18 (a) Funeral director: Commissioner of Health
(b) Address

19 MAR 3 1947 (Date rec'd by registrar) Harry J. Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 27 1947, 5:30P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 27 1947 to Feb. 27 1947, and that I last saw h. im alive on Feb. 27 1947.

| | Duration |
|---|---|
| Immediate cause of death: Cerebral hemorrhage | |
| Due to: cephalo-pelvic desproportion | |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Russell Jordan M. D.

Address: Johns Hopkins Hospital Date signed 2-28-47

VS 150

G49198 DOH G70724 BALTIMORE CITY HEALTH DEPARTMENT ✓ G49198

# CERTIFICATE OF DEATH 157c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address E. Monument St. 613
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ Dys.
(e) Length of stay in Baltimore (yrs., mos., or days) 15yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2017 N. Patterson Pk. Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Boy Mickel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Wht. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/14/47

8. AGE: Years: NB. | Months | Days | If less than one day: 1 hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Michael Mickel
13. Birthplace Virginia

MOTHER 14. Maiden Name Mary Kowalski
15. Birthplace Phila. Pa.

16 (a) Informant Michael Mickel
(b) Address 2017 N. Patterson Pk Ave.

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 3 1947

18 (a) Funeral director Commissioner of Health
(b) Address

MAR 3 1947 Huntington Williams, M.D.
(Date rec'd by Registrar)

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Feb. 14 1947, at 11 A.M. M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2/14 1947, to 2/14 1947, and that I last saw h[illegible] alive on 2/14 1947.

| | Duration |
|---|---|
| Immediate cause of death Atelectasis | |
| Due to Anencephaly | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Anencephaly

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Rubin M.D.
Address Sinai Hospital Date signed 2/21/47

X

BALTIMORE CITY HEALTH DEPARTMENT

G49199 CWE-107986 **CERTIFICATE OF DEATH** 30 E ✓ G49199 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 549 Robert Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Harris

3 (b) If veteran, name war

3 (c) Social Security Account No. 2120569

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Widower |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12-1892

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | 11 | 16 | hr. min. |

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name William
13. Birthplace Maryland

MOTHER — 14. Maiden Name June ?
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 5, 1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mr. George T. E. Gibson Sr.
(b) Address 1631 Druid Hill Ave.

19 (a) Date MAR 3 1947 (b) Signature of registrar Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION** P M

20. DATE OF DEATH Feb. 28/1947 19 at 9.20 P

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 28 1947 to Feb. 28 1947, and that I last saw him alive on Feb. 28 1947

Immediate cause of death: Cardiac failure — Duration

Due to Lyp Coletic + ASCVD

Due to Pneumonia Duration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Dougl. Waldron M. D.

Address B. C. H. Date signed 3-1-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G49200 G49200

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1417 Anchor St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Dorchester
(c) City or town Cabin Creek
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Thomas Ella Merrick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1864

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | 9 | 25 | 3 hr. AM min. |

9. Birthplace Ayres, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Twilley
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Mowbry
15. Birthplace Md.

16 (a) Informant Mrs. Helen Higgins
(b) Address 1417 Anchor St.,

17 (a) Burial (b) Date thereof 3-6-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory East New Market
Location East New Market, Md.

18 (a) Funeral director W. W. Willoughby & Son
(b) Address East New Market, Md.

19 (a) 1947 (b)
(Date filed by registrar) Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/27/47 19 to 3/3/47 19 47 and that I last saw h[illegible] alive on 3/3/47

| Immediate cause of death | Duration |
|---|---|
| (a) Coronary Thrombosis | 4 days |
| Due to: (b) Arteriosclerosis | |
| Due to: (c) | |
| Other Conditions Mercurochrome Sanguborn (Include pregnancy within 3 months of death) | 7 days |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joan Miller M. D.
Address 225 A Church Street Signed

X 3/3/47

G49201

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G49201 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 2610 Hurontstreet
(a) Baltimore City, Maryland Baltimore
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) about 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2610 Hurontstreet.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Stith Parham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male | 5. Color or race col. | 6 (a) Single, married, widowed, or divorced widowed.

6 (b) Name of husband or wife Mary E. Parham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18 1873

8. AGE: Years 73 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Sussex County Va.
(Town, county, and state)

10. Usual Occupation laborer

11. Industry or business

FATHER
12. Name Stith Parham
13. Birthplace Virginia.

MOTHER
14. Maiden Name not known
15. Birthplace not known

16 (a) Informant Margrit Heberman
(b) Address 831 E. 163rd St. N. York City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 5 1947 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Fulton Ave. Huntington Williams, M.D.

MAR 3 - 1941 (a) (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 1947 at 7 25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 21 1947 to Feb. 27 1947 and that I last saw him alive on February 27-47.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter H. Greenfield M. D.
Address 2708 Kolmar Ave. Date signed 4/28/47.

VS 150

G49202

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G49202 Registered No. 130

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 900 N. Fulton ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 16-4
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 N. Fulton ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Hannibal Brockington

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M. | Col. | Married |

6 (b) Name of husband or wife Nellie Brockington
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) March 3 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | -11 | -24 | hr. min. |

9. Birthplace Florence S.C.
(Town, county and state)
10. Usual Occupation Barber
11. Industry or business

FATHER
12. Name Glacoe Brockington
13. Birthplace S.C.

MOTHER
14. Maiden Name Julia
15. Birthplace Florence S.C.

16 (a) Informant Mrs. Lillie Saunders
(b) Address 709 N. Fulton ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 4 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
Address 929 N. Schroeder St

MAR 6 1947

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 1 1947, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 13 1947 to Mar 1 1947, and that I last saw h.i.m alive on Feb 28 1947.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Tuberculosis | ? |
| Due to — | |
| Due to — | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Douglas Sheppard
Address 604 N Fulton ave Date signed 3/3/47

X

G49203

# HEALTH DEPARTMENT—CITY OF BALTIMORE

## CERTIFICATE OF DEATH

13B

G49203

Registered No.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1844 W. Baltimore St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Mary Helen MacCurdy

If U.S. Veteran specify WAR

(a) Residence: No. 1844 West Baltimore St., St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

### PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. Color or Race | 5. Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| Female | White | Single |

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) May 9, 1902

| 7. AGE Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|
| 44 | 9 | 20 23 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 0

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

FATHER

13. NAME Samuel J. McCurdy

14. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

MOTHER

15. MAIDEN NAME B. Luella Kauffman

16. BIRTHPLACE (city or town) (State or country) Hagerstown Maryland

17. INFORMANT Miss. Ruth McCurdy
(Address) 1844 West Baltimore Street

18. BURIAL, CREMATION, OR REMOVAL
Place Druid Ridge Date March 4, 1947

19. UNDERTAKER LORING BYERS
(Address) 3005 Park Heights Avenue

20. FILED MAR 3 - 1947 Huntington Williams, M.D. Registrar.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

### MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) March 1, 1947 5:30 A.M.

22. I HEREBY CERTIFY, That I attended deceased from 2-28-43, 19... to March 1, 1947

I last saw h.er alive on March 1, 1947. Death is said to have occurred on the date stated above, at 5:30 A. m.

The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| PULMONARY TUBERCULOSIS. | |
| CHRONIC MYOCARDITIS, | |
| AURICULAR FIBRILLATION. 1 wk. prior to death. | |

Other contributory causes of importance:

Was an operation performed? No. Date of ---

For what disease or injury? ---

What test confirmed diagnosis? ... Was there an autopsy? No.

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased?

If so, specify ...

(Signed) Samuel J. Haverstock M.D.

(Address) 5-5-47 194 W Balto

G49204

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G49204 Registered No.

52B

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 16 days
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month
(e) Length of stay in Baltimore (yrs., mos., or days) —

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Harford
(c) City or town Magnolia, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME David Bond

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | N | W |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-29-1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 57 | 5 | 26 | hr. min. |

9. Birthplace Baltimore Co. Md
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Mabel Bond
(b) Address Magnolia Md

17 (a) Mar. 5 (Burial, cremation, or removal) (b) Date thereof Mar 5, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Aberdeen Maryland

18 (a) Funeral director Howard K. McComas
(b) Address Abingdon Md

19 (a) (Date received by registrar) (b) Registrar

MAR 3 1947

OVS 180

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 3-1 1947 at 8 00 PM M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-30 1946 to 3-1 1947 and that I last saw him alive on 3-1 1947

Immediate cause of death Hypostatic pneumonia — Duration

Due to Carcinoma of urinary bladder

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2-20-47

Major findings of operation: Mass in Urinary bladder

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. A. L. Jackson / M.D.
Address 600 N. Arlington Ave Date signed 3-2-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G49205 Tr. 106202

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 97

G49205 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 528 N. Monroe St Zone 23
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Frederick Milburn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Seperated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17th. 1864

8. AGE: Years 82 | Months 7 | Days 15 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Clement
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Jane Hammett
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 5 1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn 3rd

18 (a) Funeral director Henry W Jenkins Sons
(b) Address McCullh & Richard Sts

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

MAR 3 1947 VS 130

MEDICAL CERTIFICATION P.M

20. DATE OF DEATH Mar. 2nd 1947 19 , at 7.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5th 47 19 , to Mar. 2nd 19 47 , and that I last saw h im alive on Mar. 2nd 19 47

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia terminal | 30 hours |
| Due to Generalized arteriosclerosis | yrs |
| Due to Arteriosclerotic Gangrene | 2½ mos |
| Other Conditions of Left foot | |

(Include pregnancy within 3 months of death)

Date of operation 2-5-47

Major findings of operation: Gangrene foot

of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J Carroll M. D.

Address Balto City Hosps Date signed 7-2-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49206

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G49206 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave.
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 315 Overhill Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mae Templeman Taylor

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1862.

8. AGE: Years 84 | Months 10 | Days 11 | If less than one day: hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Richard N. Templeman

13. Birthplace Georgetown - D. C.

MOTHER 14. Maiden Name Maria Allen

15. Birthplace Georgetown D. C.

16 (a) Informant Hospital Record

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 5 1947 (month) (day) (year)

(c) Cemetery or crematory St Johns

Location Bayto Md.

18 (a) Funeral director Henry Weybourne & Sons

(b) Address McCulloh & Orchard

19 MAR 3 - 1947 (Date rec'd by registrar) (b) Huntington Fox Williams, M.D. Registrar

VS 15

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** March 3 1947, at 7.25 AM

**21.** I certify that death occurred on the date above stated; that I attended deceased from March 1 1947 to March 3 1947, and that I last saw her alive on March 2 1947.

| Immediate cause of death | Duration |
|---|---|
| Cardiac Failure | — |
| Due to Arteriosclerotic heart disease | 30+ yrs |
| Due to | |
| Other Conditions Arteriosclerosis, generalized Arteriosclerotic Gangrene of leg. | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

25. Signature Wayne N. Jacobs, M.D. M. D.

Address Church Home & Hosp. Date signed Mar 3, 1947.

G49207

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1312

G49207
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Fulkens + Catons Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town Arbutus Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5211 Benson Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country No

**3 (a) FULL NAME** John F. Stiebing

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-6451A

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Gabbie C. Stiebing
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) December 22-1878

8. AGE: Years 68 | Months 2 | Days 8 11 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Sheet Metal Worker

FATHER
12. Name Henry A. Stiebing
13. Birthplace Germany

MOTHER
14. Maiden Name Charlotte Eichner
15. Birthplace Germany

16 (a) Informant Robert Stiebing
(b) Address 4405 Linda Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 6-1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director George L. Sylvester
(b) Address 2101 Frederick Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 3 1947

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 3/2/47 1947 at 6:30 PM

**21.** I certify that death occurred on the date above stated; that I attended deceased from 19 to 3/2/47 19
and that I last saw h[illegible] alive on 3/2/47 19

| Immediate cause of death | Duration |
|---|---|
| (a) Cardiac Failure — Chronic Glomerulo Nephritis — Generalized Arteriosclerosis | |
| Due to (b) Myocardial failure | |
| Due to (c) | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: Yes

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23.** Signature [signature]
Address Stayner Date signed 3/2/47

G49208

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 126

Registered G49208

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 330 d St + Calhoun
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Prince Georges
(c) City or town Fremont + Hyattsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5008 · 62nd Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Francis Green Richard Francis Green

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| ? | ? |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-2-1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 7 | 4 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER 12. Name Charles Green
13. Birthplace MD

MOTHER 14. Maiden Name Emma C. Coward
15. Birthplace Maryland

16 (a) Informant — Pr.
(b) Address

17 (a) Burial (b) Date thereof 3-6-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Evergreen Cemetery
Location Hyattsville Md.

18 (a) Funeral director Francis Flach Sons
(b) Address Hyattsville Md.

MAR 4 - 1947 Huntington Williams, M.D.
(Date rec'd by local registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-3 1947 at 1:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-22 1947 to 3-3 1947 and that I last saw him alive on 3-3 1947.

Immediate cause of death Respiratory failure — Duration

Due to Uremia of Nephritis

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Incomplete

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E B Crawford M. D.
Address Union Memorial Hosp Date signed 3/5/47

VS 150

G49209

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G49209

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2303 Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2303 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Louise Eggert

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband ~~or wife~~ Herman Eggert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28th 1855

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 91 | 5 | 4 | hr. min. |

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs R Schnaderbeck
(b) Address 2303 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 MAR 4 - 1947 (Date rec'd by registrar) (b) Huntington Ave Baltimore

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 2nd 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1947 to March 2 1947 and that I last saw her alive on March 1 1947.

| Immediate cause of death | Duration |
|---|---|
| Arteriosclerotic Heart Disease | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Krause
Address 112 Chase St Date signed 3/5/47

G49210

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G49210

Registered No. 1647

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8. days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Middle River- Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 Earhardt Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: BRUCE RICHARD JENNINGS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, ~~widowed, or divorced~~: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 9th 1937

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 9 | 3 | 24 | 7 hr. ___ min. |

9. Birthplace Whitemarsh Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Davis Jennings
13. Birthplace Roanoke Va

MOTHER
14. Maiden Name Rose Salvo
15. Birthplace Balto Md.

16 (a) Informant Rose Jennings
(b) Address 1705 Earnhart Rd - Essex

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Extended

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) 3-1-1947 (Date rec'd by registrar) (b) Washington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH ~~Feb. 6~~ March 3rd 1947, at 8.30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Asphyxiation by hanging

Due to: Congestion and edema of brain

Due to: Bronchopneumonia

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-26-47 at approx. 3 P. M.
(b) Where did injury occur? Middle River Grade scho
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Found hanging - scarf tied around neck

23. Signature George R. Merrill M.D. Medical Examiner.
Date signed 3/3/47

VS 181

X

G49211

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G49211

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 141 E. Cross St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ~
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 141 E. Cross St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country ~

3 (a) FULL NAME Martha J. Bartels - Lang

3 (b) If veteran, name war ~ | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: ? LANG ?

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1883

8. AGE: Years 63 | Months 3 | Days 20 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business ~

FATHER
12. Name John Owens —
13. Birthplace Md.

MOTHER
14. Maiden Name Jane Ball
15. Birthplace Ireland

16 (a) Informant Frank Bartels (Son)
(b) Address 141 E. Cross St Balto Md

17 (a) Burial (Burial, cremation, or removal) — (b) Date thereof March 4 '37 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem.
Location B. & O. Co., Md.

18 (a) Funeral director A. Bowers Evans
(b) Address 1405 Eutaw St

19 (a) ~ (b) ~ (Signature of registrar) Registrar

MAR 4 - 1937 Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 1, 1937 at 9:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/26/1937 to 3/1/1937. and that I last saw h.C.P. alive on 3/1/1937

| Immediate cause of death | Duration |
|---|---|
| Myocardial degeneration (Antecedent) | |
| Due to Coronary Arteriosclerosis | |
| Due to | |
| Other Conditions chronic alcohol. | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. Weinberger M. D.
Address 912 Brooks Lane Date signed 3/3/37

G49212

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G49212

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1609 Clarkson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 Clarkson (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Frederick A. Klein

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 579-07-3677

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Elydia D. Klein
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) June 17, 1888

8. AGE: Years 58 | Months 8 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace: Balto Md (Town, county, and state)

10. Usual Occupation: Glazier
11. Industry or business: Hugh Reiley Co. Painters

FATHER
12. Name: Albert Frederick Klein
13. Birthplace: Germany

MOTHER
14. Maiden Name: Charlotte F. B. Klander
15. Birthplace: Germany

16 (a) Informant: Charlotte F. B. Klein (mother)
(b) Address: 1609 Clarkson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 5, 1947 (month) (day) (year)
(c) Cemetery or crematory: Leden Hill
Location: Cr. 9. 60

18 (a) Funeral director: A. Howard Evans
(b) Address: 1400 Eutaw

19 (a) Filed by registrar MAR 4 1947 (b) Huntington Williams, M.D. Registrar

VS 151

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1947, at 1:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry), Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocarditis and Myocardial Degeneration

Due to

Other Conditions Coronary Occlusion Generalized Arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Emil L. Beyer M.D. Medical Examiner.
Date signed 3/3/47

G49213 108817

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

107

Registered No. G49213

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3404 Gough St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Henrietta Duchacek

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6th. 1868

8. AGE: Years 78 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Schier ( D
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth ( D
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records )

17 (a) Burial (b) Date thereof Mar 4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Baltimore
Location

18 (a) Funeral director Philip Herwitzfons
(b) Address 2024 Orleans St

19 (a) MAR 1 1947 (b) Huntington Williams, Registrar
(Date received by Registrar)

VS 150

**MEDICAL CERTIFICATION** P.M

20. DATE OF DEATH Mar. 2nd 1947 19 ; at 2.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1st. 19 47 to Mar. 2nd 19 47 and that I last saw h er alive on Mar. 2/47 19

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia | |
| Purulent bronchitis | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bronchopneumonia Purulent bronchitis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Doyle Wallace M. D.

Address B. C. H. Date signed 3-2-47

X

G49214

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

93c

G49214
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 918 S. Paca St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 918 S. Paca St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry T. Hadaway Jr

3 (b) If veteran, name war —

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | white | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 11, 1922

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 24 | 10 | 5 | 20 hr. min. |

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Harry T. Hadaway
13. Birthplace Balto Md

MOTHER
14. Maiden Name Sadie L. Ringrose
15. Birthplace Balto Md.

16 (a) Informant Sadie L. Hadaway
(b) Address 918 S. Paca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 5 1947 (month) (day) (year)
(c) Cemetery or crematory London Park
Location City

18 (a) Funeral director Mr. Mrs. John W. Teufel Son
(b) Address 5311 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

vs 180 MAR 4 - 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Mar 1 1947, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 26 1943 to 3 1 1947
and that I last saw h alive on 19

Immediate cause of death Rheumatic C.V.D. — Duration 3 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Schafer MD

Address 1301 Arapahoe Rd Date signed 3/4/47

X

G49215 BALTIMORE CITY HEALTH DEPARTMENT G49215

TB. 101389 CERTIFICATE OF DEATH 1/13B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-mo. 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Quong Jung

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Chinese | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May ? 1886 ?

8. AGE: Years ? 60 | Months 9 5 | Days ? | If less than one day hr. min.

9. Birthplace California (Town, county, and state)

10. Usual Occupation Handy Man

11. Industry or business

FATHER 12. Name Joan Quong
13. Birthplace ~~California~~ California

MOTHER 14. Maiden Name Mary ?
15. Birthplace China

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records )

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/4/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn, Md.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. MOWEN SUC.) 100 N. NORTH AVENUE

19 (a) MAR 4 - 1947 (Date received by registrar) Huntington Williams

**MEDICAL CERTIFICATION** P M

20. DATE OF DEATH Mar. 2- 1947 1947, at 4.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 18/46 19 Mar. 2.47 19, and that I last saw h. im alive on Mar. 2nd 1947.

| Immediate cause of death | Duration |
|---|---|
| Resp. failure | |
| Due to Pul. Tuberculosis | 2 yrs. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: No Post

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Deane M.D. M. D.
Address B. C. H. Date signed 3-2-47

VS 150

X

G49216

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH √83a

Registered No. G49216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 12 11 Light St
(c) Hospital or institution: SBGH

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 da
(e) Length of stay in Baltimore (yrs., mos., or days) ?

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 734 S. Broadway (If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Fred Stone

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | ? |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 20, 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 8 | 3 | 11 | hr. min. |

9. Birthplace ? (Town, county, and state)
10. Usual Occupation Seaman
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace ?

MOTHER
14. Maiden Name Unknown
15. Birthplace ?

16 (a) Informant Mrs. Forback
(b) Address 734 S. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 4 47 (month) (day) (year)
(c) Cemetery or crematory St. Matthews
Location Gorsuch Pk

18 (a) Funeral director Tilden & Zeile
(b) Address 402 S. Broadway

19 (a) ~~Filed~~ 1947 (Date received by registrar) (b) Huntington Williams MD

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 3 - 1 1947 at 9:08 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2-12 1947 to 3/1 1947 and that I last saw him alive on 3/1 1947.

Immediate cause of death Hospital Tetany Failure — Duration
Due to acidemia.
Due to Cerebral Hemorrhage (type)
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23.** Signature H. Brueckner
Address Baltimore Md Date signed 3-1-47

X

G49217

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 97

Registered No. G49217

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3344 Chestnut ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3344 Chestnut Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Andrew L. Freeberger

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Mary E. Freeberger

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1-1866

8. AGE: Years 80 Months 2 Days 0 If less than one day hr. min.

9. Birthplace Baltimore Md
(town, county, and state)

10. Usual Occupation Retired

11. Industry or business —

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Blanche Freeberger
(b) Address 3344 Chestnut Ave

17 (a) Burial (b) Date thereof 3/4/47
(burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Green Ridge
Location Balto Co Md

18 (a) Funeral director Geo L. Boyer Jr
(b) Address 1512 Hillin St

19. Filed 4 Mar 1947 Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 3-1 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-25 1947 to 3/1 1947, and that I last saw him alive on 2/28/47 1947.

Immediate cause of death Asphyxia
Pneumonia

Due to Senility

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

| Duration |
|---|
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Huntington Williams M.D.

Address 1123 St Paul St Date signed 3/3/47

VS 150

G19218

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G19218 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2729 E. Madison Street
(c) Hospital or institution:
7-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimcre-5
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2729 E. Madison Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** HARRY G. ROCK.,

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:
4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Edith (nee Tucker)
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 29 1881
8. AGE: Years 65 | Months 11 | Days 3 | If less than one day hr. min.
9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Frank Rock
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name A lice Davis
15. Birthplace Baltimcre, Md.

16 (a) Informant Edith Rock-wife
(b) Address 2729 E. Madison Street, -5

17 (a) Burial (b) Date thereof 3/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimcre Cemetery.,
Location North Ave & Rose St.,

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street.

19 (a) 4 - 1947 (Date received by Registrar) Huntington Williams M.D. (Registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 1st 1947, at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6 1946, to March 1 1947, and that I last saw alive on March 1 1947

| | Duration |
|---|---|
| Immediate cause of death: Coronary Occlusion | 3/1/47 |
| Due to: a Myocarditis | 1/1945 |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Williams Rogers M.D.
Address 801 Kensington Date signed 3/5/47

G49219 B.C.g-59807

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V 107

G49219 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1231 Myrtle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** James Farmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Black | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/21/26

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 4 16 | 7 | hr. min. |

9. Birthplace Balto Md
(Town, county, and State)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Farmer
13. Birthplace

MOTHER
14. Maiden Name Irene Wilkins
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 3-5-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Baltimore, Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

MAR 4 - 1947
(Date rec'd by registrar) (b) Huntington Williams Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb. 28 1947 at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

| Immediate cause of death | Duration |
|---|---|
| Pneumonia | |
| Respiratory failure | |
| Due to Pneumonia | two |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Burton Childs

Address Johns Hopkins Hosp Date signed 2-28-47

VS 150

G49220 G49220

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 192 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

**3 (a) FULL NAME** Elizabeth Reynolds

3 (b) If veteran, name war

3 (c) Social Security Account No. xx

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | white | widowed |

6 (b) Name of husband or wife Frank P. Reynolds

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 3 | 6 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name John F. Brachen
13. Birthplace Baltimore

MOTHER
14. Maiden Name Eliz. Tonner
15. Birthplace Baltimore

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 5, 1947 (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Weidefeld
(b) Address 900 Biddle St East

19 (a) Date rec'd by registrar Mar 4 1947 (b) Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 2 1947, at 8-55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 27 1947, to Mch 1947, and that I last saw h.er alive on 19

| Immediate cause of death | Duration |
|---|---|
| Acute Dilatation Heart | 1 day |
| Due to Mitral Stenosis | 6 yr |
| Due to | |
| Other Conditions Large Cystic Goitre | 20 yr |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Gill Hall M. D.
Address 1631 E North ave Date signed 3/9/47

VS 3

X

G49221

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

Registered No. G49221

CWK-78214

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr. 2 mos. 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Street Address
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roy Keith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9- 1869

8. AGE: Years 77 | Months 9 | Days 12 | If less than one day hr. min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Keith
13. Birthplace England

MOTHER
14. Maiden Name Ellen Taylor
15. Birthplace England

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Johns Hopkins Medical School MAR 4 1947

18 (a) Funeral director Commissioner of Health

(b) Address

MAR 4 1947 Huntington Williams M.D.
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 21 19 47, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 25 19 42 to Feb. 21 19 47, and that I last saw h. im alive on Feb. 21 19 47.

| Immediate cause of death | Duration |
|---|---|
| Coronary occlusion | |
| Due to arteriosclerosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin C. Evans M. D.
Address Balto. City Hosp. Date signed 2-28-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Birth Certificate G 72641

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

Registered No. G49222

G49222

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Broadway
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 7hrs.

**2. USUAL RESIDENCE OF DECEASED:** (Parents Address)
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 40 Hawthorne Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Riemer

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Newborn

6 (b) Name of husband or wife: Infant

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) March 1 1947

8. AGE: Years | Months | Days | If less than one day: 7 hr. 24 min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business

FATHER
12. Name John Frederich Riemer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Grace Williamson
15. Birthplace Baltimore Md.

16 (a) Informant John Frederich Riemer
(b) Address 40 Hawthorne Ave, Balt.

17 (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School MAR 4 1947

18 (a) Funeral director Commissioner of Health

(b) Address

MAR 4 1947 [illegible] M.D.
(Date rec'd by registrar)

VS 180

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 1947 at 5:16 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1947 to March 1 1947 and that I last saw h[illegible] alive on March 1 1947

Immediate cause of death: Prematurity — Duration

Due to: Premature Labor of Mother

Due to:

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation: None

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: No
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nicholas J. Fokkema M. D.
Address Church Home & Hospital Date signed 3-1-47

X

G49223

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

Registered No. G49223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGINS RESERVED FOR BINDING

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address Linden & Madison Ave

(c) Hospital or institution: Maryland G. Hosp. - 10 mos 25 days

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State (b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2415 Guilford Ave

(If rural give location)

(e) Citizen of foreign country? Yes (Yes or No)

If yes, name country Lithuania

**3 (a) FULL NAME** Anna Zulius

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-5613

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | S |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2 1899

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 47 | 6 | 26 | hr. min. |

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation Tailoress

11. Industry or business Tobo. Bus.

FATHER

12. Name VINCENT ZULIUS

13. Birthplace LITHUANIA

MOTHER

14. Maiden Name MAGDALENE JURKSHUS

15. Birthplace LITHUANIA

16 (a) Informant JOSEPH ZULIUS

(b) Address 104 SYMINGTON AVE

17 (a) CREMATED (Burial, cremation, or removal) (b) Date thereof 3-4-47 (month) (day) (year)

(c) Cemetery or crematory HOLY REDEEMER

Location BELAIR RD.

18 (a) Funeral director Charles W. Kackmeister

(b) Address 703 McHenry St

19 (a) A.D. 1947 (b) Huntingtown, Williams Registrar

(Date received by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Feb 28 / 1947 at 7:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/31/1946 to 2/28/1947 and that I last saw her alive on 2/28/1947.

Immediate cause of death Cachexia

Due to Generalized Carcinoma Tonsils

Due to Ca of Breast

Other Conditions Pathological fracture left femur and pelvic bones

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy:

| Duration |
|---|
| 10 mos |
| 25 days |

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. C. Gonzales M.D.

Address Maryland G. Hospital Date signed 2/28/47

VS 150

X

G49224

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 13 B

Registered No. G49224

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Greenspring & Belvedere Aves.
(c) Hospital or institution: Levindale Hebrew Home & Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Green Spring & Belvedere Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PHILIP JOBLIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6 (b) Name of husband or wife Janina Joblin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | | | hr. min. |

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Jacob Joblin
13. Birthplace Russia

MOTHER
14. Maiden Name Rose —
15. Birthplace Russia

16 (a) Informant Leon Joblin
(b) Address 2200 Whittier Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-4-47 (month) (day) (year)
(c) Cemetery or crematory Sharon Hill Rd
Location Sharon Hill Rd

18 (a) Funeral director Jos. Rizza Inc
(b) Address 1329 E. Balto St

19 (a) (Date rec'd by registrar) (b) Registered No.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 3-3 1947, at 9:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17 1944 to 3-3 1947 and that I last saw h(im) alive on 3-3 1947. Immediate cause of death Bronchiectasis

Duration

Bronchitis.

Due to

Due to

Other Conditions Chron. fibrous Tb. of lungs
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Boyd M. D.
Address Levindale Home Date signed 3-3-47

VS 180 MAR 4 - 1947 Huntington

106 B

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G49225

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 195c

Registered No. G49225

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1271 Sargeant St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1271 Sargeant St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel W. Ludwig

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sadie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1879

8. AGE: Years 67 | Months 9 | Days 18 21 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county and state)

10. Usual Occupation Carpenter.
11. Industry or business U. S. Steel Co.

FATHER
12. Name John Ludwig
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Md

16 (a) Informant Mrs Sadie Ludwig
(b) Address 1271 Sargeant St

17 (a) Burial, cremation, or removal: Burial (b) Date thereof 3/5/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cathedral
Location 4700 Old Frederick Ave

18 (a) Funeral director John J. Brown & Son
(b) Address 2018 Gilmor St

19 (a) [illegible] (b) Registrar

MAR 4 1947 Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 3/2/1947, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1944, to 3-2- 1947, and that I last saw him alive on 3-1- 1947.

Immediate cause of death: Organic heart disease

Due to:

Due to:

Other Conditions: Emphysema

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:

of autopsy:

Duration: Unknown

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chester Riland, M. D.
Address 2532 Edmondson Ave Date signed 3-3-47.

G49226

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 55c

G49226 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 902 N. Chester
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 902 N. Chester
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Grill

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | Widowed |

6 (b) Name of husband or wife John Grill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1863

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 10 | 35 | hr. min. |

9. Birthplace Athenia (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER 12. Name John Carey
13. Birthplace Athenia

MOTHER 14. Maiden Name Ann Brown
15. Birthplace Athenia

16 (a) Informant Elizabeth Rogers
(b) Address 2117 E. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Frank Brachbar
(b) Address 900 N. Chester St

19 (a) MAR 4 - 1947 (Date rec'd by registrar) (b) Huntington Mills Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 1 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to March 1 1947, and that I last saw h alive on 1947

| Duration |
|---|
| 2 hr |

Immediate cause of death Coma
Due to Thrombosis
Due to Myocardial Degeneration
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Fred Rupchis
Address 900 N. Chester St

VS 150

G49227

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered File G49227

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 5308 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town 5308 W. North Ave.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** GERTRUDE ELIZABETH WOLFF

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | no |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11, 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 2 | 21 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Frank A. Wolff
13. Birthplace Germany

MOTHER
14. Maiden Name Theresa M. Haupt
15. Birthplace Germany

16 (a) Informant Mr. Lyman H. Wolff
(b) Address 1512 Kearny St., N.E., Wash. D. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 MAR 4 – 1947 Received by registrar Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 16 1946 to Mar 2 1947
and that I last saw her alive on Mar 1 1947

Immediate cause of death: Senile Cardiac Debilitation — Duration
Due to Chronic Myocarditis
Due to age.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Herbert C. Blake M. D.
Address Date signed

X

G49228

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 58B

G49228 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2128 E. Fayette, St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2128 Fayette, St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** GENEVIEVE C. NEUNSINGER

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife Giovanni
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6, 1917

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 29 | 6 | 25 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Thomas Buccheri
13. Birthplace Italy

MOTHER
14. Maiden Name Mary Amello
15. Birthplace Italy

16 (a) Informant Giovanni Neunsinger
(b) Address 1820 Bell, Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 5 47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair, Rd.

18 (a) Funeral director Lilly + Zeuler, Inc.
(b) Address 403 S Wolfe St

19 (a) 1947 (Date received by registrar) (b) Lington Williams (Signature of registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 1 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 14 1947 to March 1 1947
and that I last saw h[illegible] alive on 3/1 1947.

| Immediate cause of death | Duration |
|---|---|
| (a) Pulmonary Embolism Endocarditis (Rheumatic) | 2 wks. |
| Due to (b) Rheumatic fever | ? |
| Due to (c) | |
| Other Conditions Cardiac Asthma | ? |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [illegible]
Address 2002 E. Fayette Date signed 3/5/47 M.D.

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G49229 / 131a

Registered No. G49229

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 416 No. Patterson Pk. Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 N. Patterson Park Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Philip A. Velte

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Elizabeth Hartmann
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 6/13/1886
8. AGE: Years 60 | Months 8 | Days 19 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Self

FATHER
12. Name Charles A. Velte
13. Birthplace Germany

MOTHER
14. Maiden Name Anna (unkown)
15. Birthplace Unknown

16 (a) Informant Charles A. Velte
(b) Address 140 Murdock Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/1947 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location German Hill Road

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 So. Wolfe Street

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 7

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1947, at 6.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 28 1947, to 3-2 1947, and that I last saw h/m alive on 3-2 1947

| Immediate cause of death | Duration |
|---|---|
| ARTERIOSCLEROSIS- | 2-YRS. |
| Due to HYPERTENSIVE-CARDIO-VASCULAR-RENAL DISEASE | |
| Due to | |
| Other Conditions CEREBRAL HEMORRHAGE | 3 DAYS |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Vince F. Kavanagh M.D.
Address 325 W. Saratoga St. Date signed 3-4-47 M. D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49230

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 167

Registered No. G49230

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1834 Orleans St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lucille BEDFORD TRUSTY

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | Married |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1922

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 24 | 8 | 22 | hr. min. |

9. Birthplace Baltimore Co. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name David Bedford
13. Birthplace Balto. Co. Md

MOTHER
14. Maiden Name Bernice Alley
15. Birthplace Balto. Co. Md

16 (a) Informant Bernice Alley
(b) Address 2248 N. Duncan St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 3/6/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brandt & Ave

19 MAR 4 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

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**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 2, 1947, at 1A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Stab-wound of heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/2/47 at 12:45 A.M.
(b) Where did injury occur? 1834 Orleans St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Stabbing

23. Signature George L. Merrill M.D. Medical Examiner.

Date signed 3/3/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49231

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 55E

Registered No. G49231

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N. Carlin's
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(c) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 S. Eaton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs. Alexandra Santoni

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fr.

5. Color or race W

6 (a) ~~Single, married~~, widowed, or divorced.

6 (b) Name of husband or wife late Paolo

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25 1878

8. AGE: Years 68 | Months 3 | Days 5 7 | If less than one day ____ hr. ____ min.

9. Birthplace Camerino (Macerata) Italy
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business home

FATHER 12. Name Luigi Capponi

13. Birthplace Italy

MOTHER 14. Maiden Name Rosa Ferrante

15. Birthplace Italy

16 (a) Informant Savino Santoni (Son)

(b) Address 119 S. Eaton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 6/47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della, Rosa

(b) Address 52 N. Morley St.

(c) (Date rec'd by registrar) MAR 4 1947 Huntington Williams, M.D.

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## MEDICAL CERTIFICATION

20. DATE OF DEATH 3/2/47 19 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/21 19 47 to 3/2/47.
and that I last saw her alive on 3/2/47 19

| Immediate cause of death | Duration |
|---|---|
| Cardio-Resp. failure | |
| Due to Carcinomatosis | |
| Due to primary Site undetermined | |
| Other Conditions Secondary Anemia | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Anthony Jones M.D.

Address 119 S. Eaton St. Date signed 3/7/47

G49232

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 309

G49232
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1309 E. Eager St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 E. Eager St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jack Lane
3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M. | Col. | Widower |

6 (b) Name of husband or wife Carrie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 21 1896

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | 1 | 26 | hr. min. |

9. Birthplace S. C.
(Town, county, and state)
10. Usual Occupation Stevedore
11. Industry or business

FATHER
12. Name Harry Lane
13. Birthplace S. C.

MOTHER
14. Maiden Name Zilla Bethea
15. Birthplace S. C.

16 (a) Informant Jennie Davis
(b) Address 1309 E Eager St

17 (a) Burial (b) Date thereof March 4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A.A. County

18 (a) Funeral director Mrs. Ruth A. Elliott's Dept.
(b) Address 1129 N. Carlton St

19 (a) 1947 Clayton Williams, Registrar
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2/28 1947 at 5:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/25 1947 to 2/28 1947 and that I last saw deceased alive on 2/28 1947.

| Immediate cause of death | Duration |
|---|---|
| Ruptured aorta aneurysm | |
| Due to Hypertension | |
| Due to | |
| Other Conditions Cardiac Hypertrophy | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Ralph J. Upperman M.D.
Address 429 E. Preston St. Date signed 3/3/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G49233

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G49233 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 7550 W. Lombard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7550 W. Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew J. White

3 (b) If veteran, name war None

3 (c) Social Security Account No. 225-03-7075

4 Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Catherine C. White

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 30. 1898

8. AGE: Years 48 | Months 3 | Days 2 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Counter man

11. Industry or business Restaurant

FATHER 12. Name Horatio White

13. Birthplace Virginia

MOTHER 14. Maiden Name Barbara McCormack

15. Birthplace Virginia

16 (a) Informant Catherine C. White

(b) Address 7550 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 5-1947 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location City

18 (a) Funeral director Roll & B. M. Walker

(b) Address Pratt & Steiker Sts

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 4 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 2 1947, at 12:00 midnite M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27, 1946 to March 2 1947 and that I last saw him alive on March 2 1947.

| Immediate cause of death | Duration |
|---|---|
| Coronary thrombosis | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton Hamrick M. D.

Address 142 W. Fayette St Date signed 3/3/47

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G49234 Registered No. G49234

C-106140

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 42- 5- 21-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2001 Madison Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Lillian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11-1904

8. AGE: Years 42 | Months 5 | Days 21 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Green
13. Birthplace Maryland

MOTHER
14. Maiden Name Matilda Brooks
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location MD

18 (a) Funeral director Edw. A. Kelson
(b) Address 1303 Russelman St

19 (a) (Date rec'd by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1947, at 6:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from February 1947 to March 2 1947, and that I last saw h... alive on March 2 1947.

Immediate cause of death: Pulmonary Tuberculosis, Far Advanced — Duration: 2 mos +

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. J. Hunt (Balt. City Hosp.) Date signed 3-3-47

MAR 4 - 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G49235

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

Registered No. G49235

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1805 N. Gay St.
(c) Hospital or institution: F

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1805 N. Gay St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Annie Weiner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles Weiner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 1st 1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 56 | 4 | 1 | hr. min. |

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John E. Wallace
13. Birthplace Md

MOTHER
14. Maiden Name Anna Despaud
15. Birthplace Md

16 (a) Informant Mr. Chas. Weiner
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 6 1947 (month) (day) (year)
(c) Cemetery or crematory Morelands
Location Taylor

18 (a) Funeral director Les G. Leggett
(b) Address 1701-03 N. Pattison St

19 (a) (Date rec'd by registrar) (b) Registrar

Mrs. 1947 Huntington Williams, M.D.

MAR 4 - 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3-2-47, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 Jan 1947 to 2 Mar 1947, and that I last saw h[illegible] alive on 1 March 1947.

Immediate cause of death: Carcinoma, Breast c generalized
Metastases

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

| Duration |
|---|
| 1 yr |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.

Address 1513 N. [illegible] Date signed [illegible]

G49236

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1108

Registered No. G49236

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1155 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Effie Gibson

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1910

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 37 | | | hr. min. |

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Gibson
13. Birthplace Charleston W. Va

MOTHER 14. Maiden Name —
15. Birthplace —

16 (a) Informant Noble & Long
(b) Address Charleston W. Va

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Charleston W. Va

18 (a) Funeral director Leo G. Crook
(b) Address 1701-03 N. Patterson Park ave

19 MAR 4 - 1947 Washington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 191

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** March 4 1947, at 1:05 PM

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions Cirrhosis of liver

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed 3-4-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49237

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

131a

Registered G49237

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 702 S East, Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702 S. East Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** ANNA HOESCH

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife George Hoesch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 12, 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 11 | 20 21 | hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant George Hoesch
(b) Address 702 S. East Ave

17 (a) Burial (b) Date thereof 3 5 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S Wolfe St

19 (a) (b)
(Date rec'd by registr.) (Signature)

MAR 4 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1946 to Mar 1 1947 and that I last saw h. alive on Feb 9 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Cardiac Failure | |
| Due to Cardiac Vascular Renal Diseases. | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward A. Dunger M. D.
Address 3503 Fait ave Date signed Mar 3 47

X

G49238

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

131a

G49238 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raynor
(c) Hospital or institution:
West Baltimore Gen'l
(d) Length of stay in hospital or inst. (yrs., mos., or days): Life
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give name)
(d) Street No. 720 Linnard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. OREM — Aram

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife late Vaughn A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name John W. Aram
13. Birthplace Md

MOTHER 14. Maiden Name Sarah Robinson
15. Birthplace Md

16 (a) Informant E. O. Harrington
(b) Address 4 Overbrook Rd. Cat.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/47 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Harry F. Withe
(b) Address 410 N. Edmondson Ave

19 (a) MAR 4 1947 (Date rec'd by registrar) (b) Washington Willi... Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 3/1/47 19.... at 9:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 19 47 to 3/1 19 47 and that I last saw h.. alive on 3/1 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | |
| Due to Hypertension | |
| Due to Cardio-Vasc-Renal | |
| Due to Disease | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Berdansky M. D.
Address West Balto Gen'l Date signed 3/1/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write up the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G49239 G49239

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 31 S Augusta Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 31 S Augusta Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary A. Cullen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6 - 1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 2 | 27 | hr. min. |

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Patrick Cullen
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann Mears
15. Birthplace Ireland

16 (a) Informant Margaret M. Quigley
(b) Address 31 S. Augusta Ave.

17 (a) Burial (b) Date thereof 3-6-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) (Date rec'd by registrar) MAR 8 1947 Huntington Williamsport Md

VS

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** March 2 1947, at 11:45 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ✓ death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Reifsnider M.D.
Medical Examiner
Date signed 3 March 47

G49240

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G49240 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2508 Shirly Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-
(e) Length of stay in Baltimore (yrs., mos., or days) 41 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County White
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2508 Shirley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Adelina B. Perella

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | married |

6 (b) Name of husband or wife: XXXXX Alfonso Perella
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | XX | 27 | hr. min. |

9. Birthplace Pianella Pescara Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business home

FATHER
12. Name Vincenzo Bufarale
13. Birthplace Italy

MOTHER
14. Maiden Name Carmela Prosperi
15. Birthplace Italy

16 (a) Informant Alfonso Perella (Husband)
(b) Address 2508 Shirley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 5 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.
18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.
19 (a) MAR 1 - 1947 (Date received by registrar) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 2 1947, at 9 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 1947 to March 2 1947 and that I last saw him alive on March 2 1947.

Immediate cause of death Coronary Thrombosis — Duration 15?
Due to
Due to
Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fr. L. de Barbieri, M. D.
Address 4723 Park Heights Ave Date signed 3/3/47

VS 150

X

G49241 G49241

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 52a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 410 Cedarcroft Rd
(c) Hospital or institution: at home 27-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltcity.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 Cedarcroft Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Howard Dashiell

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed or divorced: married
6 (b) Name of husband or wife: Adeline T. Dashiell
6 (c) If alive, give age 73 years
7. Birth date of deceased (mo., day, yr.) Dec 9 1873
8. AGE: Years 73 Months 2 Days 21 If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Cashier & Director
11. Industry or business Calvert Bank

FATHER
12. Name Wm. H. Dashiell
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Jane Holbrook
15. Birthplace Baltimore Md

16 (a) Informant Mrs Adeline T. Dashiell (wife)
(b) Address 410 Cedarcroft Road
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-47 (month) (day) (year)
(c) Cemetery or crematory David Rittase
Location Pikesville Md
18 (a) Funeral director Edward Mapp & Co.
(b) Address 108 W Mt Royal Ave
19 (a) Huntington Williams, Md (b) Registrar
(Date received by registrar)
MAR 4 1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 2nd 1947, at 3 30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 1925, to March 2nd 1947, and that I last saw him alive on March 2nd 1947.

| Immediate cause of death | Duration |
|---|---|
| Hypertensive Heart Disease | 6 mos. |
| Due to — | |
| Due to — | |
| Other Conditions — | |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature A. S. Claypoole M.D.
Address 6 & 10 York Rd Date signed March 4 1947

G49242

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 97

G49242
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 6 Upland Road
(c) Hospital or institution Roland Park Apartments (or home)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 2
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 Upland Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rosalie Tormey Power

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: John Wm. Power
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 21 1863

8. AGE: Years 83 | Months 11 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Leonard Tormey
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Ellen Jenkins
15. Birthplace Balto Md.

16 (a) Informant Mr. John Leonard Thorn - (Son)
(b) Address 62 Upland Rd - City - 10

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Shivers & Morris Company
(b) Address 108 W. North Ave.

1947 (Date rec'd by registrar) (b) Thorpe Farrington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Mar 3 1947 at 4-05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to Mar 1947
and that I last saw her alive on Feb 12 1947.

Immediate cause of death: Cardio vascular failure — Duration: 1 hour
Due to: Hypertension + arterio sclerosis — 2 years +
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Franklin E Leslie M. D.
Address 1101 E Pratt Date signed Mar 4, 47

VS 150

G49243

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G49243 Registered No. 164c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 Maiden Choice Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** William EDGAR Fisher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Clara C. Fisher

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12 1895

8. AGE: Years 52 | Months 0 | Days 27 | If less than one day 19 hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Refrigerator Repairman

11. Industry or business

FATHER 12. Name George Fisher
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Mary R Jones
15. Birthplace Baltimore Md

16 (a) Informant Geo C Fisher
(b) Address 106 Maiden Choice Lane

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 3/6/47 (month) (day) (year)

(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilson & Son Inc
(b) Address 1217 E Fort Ave

MAR 5 - 1947 (Date rec'd by registrar) Huntington Williams Registrar

VS 181

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 3/3/47 19 , at 3:52 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gun shot wound right Temple .32 Revolver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3/3/47 at 12:30 P.M.
(b) Where did injury occur? Belfast Spruce Road
(c) Did injury occur at home, on farm, industrial place, in public place? County Road While at work? No
(d) Means of injury Self Inflicted (32 Cal revolver)

23. Signature John R Peters M.D. Medical Examiner.
Date signed 3/4/47

X

G49244 B.C.9-72533

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

G49244 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1640 N. Gilmor St.
(c) Hospital or institution: — 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) 1 20 60m

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto.
(c) City or town Baltimore 17 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1640 N. Gilmor St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

**3 (a) FULL NAME** Baby Boy Mayden

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | Black | Single |

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 March 1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | 1 hr. 20 min. |

9. Birthplace Baltimore (Balto.), Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Herman Evans
FATHER 13. Birthplace Petersburg, Va.

MOTHER 14. Maiden Name Ida Wash Mayden
MOTHER 15. Birthplace Richmond, Virginia

16 (a) Informant Ida Wash Mayden
(b) Address Richmond, Virginia

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Dft Dis Post
Location Johns Hopkins Medical School MAR 4 1947
18 (a) Funeral director Commissioner of Health
(b) Address
19 MAR 5 1947 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3 March 1947, at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3 March 1947, to 3 March 1947, and that I last saw him alive on 3 March 1947

| Immediate cause of death | Duration |
|---|---|
| Atelectasis, Pulmonary Bilateral | |
| Cardiac & respiratory failure | |
| Due to Prematurity (32 wks) | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature Clarence A. Marbury M. D.
Address 800 University Pkwy Date signed 3 Mar 47

VS 150

X

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G49245

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1310

Registered No. G49245

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 dys.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 N. Carey St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward B. Parker
3 (b) If veteran, name war
3 (c) Social Security Account No.
4 Sex M
5. Color or race N
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Alice Parker
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9/17/83
8. AGE: Years 63 Months 5 Days 13 If less than one day hr. min. 15
9. Birthplace Harford County, Md. (Town, county, and state)
10. Usual Occupation Ret'd Ply'd
11. Industry or business
12. Name William Parker
13. Birthplace md
14. Maiden Name Scarlet Brooks
15. Birthplace md
16 (a) Informant Alice Parker
(b) Address 1125 N. Carey ST
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn.
Location md
18 (a) Funeral director George H. Kelson
(b) Address 1303 Presstman ST
19 (a) MAR 5 - 1947 (Registered by registrar) Registrar

Acting for Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 3/2/1947, at 1:00 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 2/6/1947 to 3/2/1947, and that I last saw h. alive on 3/2/1947.

| Immediate cause of death | Duration |
|---|---|
| Cong. Heart Failure | |
| Cardio-Vascular Renal Disease | 6 mos. |
| Due to Hypertension | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature J. K. Adams M.D.
Address 222 N. Carolina Date signed X 3-3-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49246

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

X 131B

Registered No. 049246

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3902 GREENMOUNT AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3DAYS

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County BALTIMORE
(c) City or town WHITE HALL
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** NELLIE R. PEARCE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: CHARLES L. PEARCE

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) JULY 30, 1881

8. AGE: Years 65 | Months 7 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace WHITEFORD, HARFORD CO. MD.
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business OWN HOME

FATHER 12. Name JOHN MAE SCARBROUGH

13. Birthplace HARFORD CO. MD.

MOTHER 14. Maiden Name VIOLA C. MALONE

15. Birthplace LANCASTER CO. PENNA.

16 (a) Informant CHARLES L. PEARCE

(b) Address WHITE HALL, MD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof MAR. 6 1947 (month) (day) (year)

(c) Cemetery or crematory VERNON

Location WHITE HALL MD.

18 (a) Funeral director Howard A. Longbrake

(b) Address White Hall Md

19 (a) (Date rec'd by Local Reg.) (b) Registrar

MAR 6 1947 Huntington Williams, M.D.

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 3 MARCH 1947, at 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from October 1945 to 3 MARCH 1947 and that I last saw her alive on 3 MARCH 1947.

| | Duration |
|---|---|
| Immediate cause of death UREMIA AND BRONCHO-PNEUMONIA | 2 DAYS |
| Due to CHRONIC NEPHRITIS | 3 YRS |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lloyd E. Saylor, M.D. M. D.

Address 3902 Greenmount Ave. Date signed 3 MAR 1947

X

G49247

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Corner G49247 / 46 B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital #6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 Kresson St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** DANIEL WALKER CAMERON

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | 717-07-8611 |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | |

6 (b) Name of husband or wife Sarah E. Cameron
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-11-82

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 3 | 22 | hr. min. |

9. Birthplace Md Balto. Co. (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business R.R. (Penna. R. R.)

FATHER
12. Name Wm Cameron
13. Birthplace Va.

MOTHER
14. Maiden Name Harriet Dasbell Stiffler
15. Birthplace Md

16 (a) Informant Wife
(b) Address 900 Kresson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cem.
Location Baltimore County, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date rec'd by registrar) Registrar

MAR 5 - 1947

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 3-3 1947 at 9 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 2-25 1947 to 3-3 1947 and that I last saw him alive on 3-3- 1947.

Immediate cause of death Obstruction of Pylorus

Due to Carcinoma of Pylorus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3-1-47

Major findings of operation: see above

of autopsy:

Duration: 1 Mo. 1 Yr.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley B. Klyanovicz MD
Address Franklin Sq. Hosp. Date signed 3-3 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49248

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered G49248

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4660 Park Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4660 Park Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** CARROLL HARVEY HUDSON

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 216-05-8735

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mariel Roberta Hudson

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 67 | 4 | 6 | hr. min. |

9. Birthplace Gloucester Co., Va. (Town, county, and state)
10. Usual Occupation Shipping Clerk
11. Industry or business F. A. Davis Co.

FATHER
12. Name Clement Wilson Hudson
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Spillman
15. Birthplace Va.

16 (a) Informant Mrs. MarielRoberta Hudson
(b) Address 4660 Park Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) (Date rec'd by registrar) Registrar

MAR 5 1947

VS 150

Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1947 at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to Mch 3 1947, and that I last saw him alive on Mch 1 1947.

| Immediate cause of death | Duration |
|---|---|
| Myocarditis | |
| Due to Arteriosclerosis | 5 yrs |
| Due to Senility | — |
| Other Conditions Mental Disintegration | |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. J. Wells M.D.
Address 5276 Park Heights Date signed Mch 4 47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49249

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

G49249 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2958 Wyman Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ella Parker Ross

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | married |

6 (b) Name of husband or wife Benjamin F. Ross
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1906

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 40 | 3 | 19 | hr. min. |

9. Birthplace Salisbury, Md.
(Town, county, and state)
10. Usual Occupation Dressmaker - self
11. Industry or business

FATHER
12. Name William S. Parker
13. Birthplace Dorchester Co., Md.

MOTHER
14. Maiden Name Edith Robinson
15. Birthplace Dorchester Co., Md.

16 (a) Informant Mr. Benjamin F. Ross
(b) Address 2958 Wyman Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 7, 1947 (month) (day) (year)
(c) Cemetery or crematory Parson's Cem.
Location Salisbury, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 181 MAR 5 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 4, 1947, at 1.20 a M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral edema

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 2/4/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49250

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 54B

Registered No. G49250

**1. PLACE OF DEATH** 2503 Edmondson Ave.
(a) Baltimore City, Maryland
(b) Street address 2503 Edmondson Ave.
(c) Hospital or institution: 0
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2503 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** G. Lester Weber.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | married |

6 (b) Name of husband or wife Minnie H. Weber.
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1892

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | 1 | 20 | hr. min. |

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Funeral Director
11. Industry or business

FATHER
12. Name George Weber.
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Lentz
15. Birthplace Balto. Md.

16 (a) Informant Minnie H. Weber
(b) Address 2503 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 7 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Dill Bros.
(b) Address 3109 Frederick Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** March 4 1947, at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1947 to March 4 1947 and that I last saw h. alive on March 4 1947

Immediate cause of death: Sclerosis of pulmonary Coronary — Duration 4 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Pleasants M.D.
Address 230 E. Lanvale Date signed 3/4/47

vs MAR 5 - 1947 Huntington Williams M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49251

AB-106218

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G49251

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 10

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 921 Forrest St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Minnie Holmes

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | Widowed |

6 (b) Name of husband or wife Douglas (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28-1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 6 | 3 | hr. min. |

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name William Swan (D

13. Birthplace Maryland

MOTHER

14. Maiden Name Amelia Brown (D

15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 6th 1947 (month) (day) (year)

(c) Cemetery or crematory Mt Zion

Location Balto, Md

18 (a) Funeral director Byron T Maginnis M. Hooper

(b) Address 721 Patapsco St

19 (a) (b) Registrar

(Date rec'd by registrar) MAR 5 - 1947

**MEDICAL CERTIFICATION** AM

20. DATE OF DEATH March 1 1947 at 9.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-6 1947 to 3-1- 1947 and that I last saw her alive on 3-1- 1947

Immediate cause of death Probably coronary occlusion — Duration

Due to HCVD & auricular fibrillation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. Doyle Waldron M. D.

Address BCH. Date signed 3/1/47

MARGIN RESERVED FOR BINDING

Every item of information should be carefully supplied. The causes of death clearly and legibly.

PRINT PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The causes of death clearly and legibly. Items especially important. Physicians: please write the causes of death clearly and legibly.

G49252

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 93E

Registered No. G49252

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 246 Franklin Town Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) one 20
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 246 Franklin Town Rd
(If rural give location)
(e) If foreign born, how long in U. S. A.? N years

**3 (a) FULL NAME** Harry E Crouse

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 20 - 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 2 | 6 13 | hr. min. |

9. Birthplace Carroll Co Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Rufus Crouse
13. Birthplace Carroll Co

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Reta Elkins
(b) Address 2436 Franklin St

17 (a) Burial (b) Date thereof Mar 5-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Strickers Comm
Location Carroll Co Md

18 (a) Funeral director Charles P Powell
(b) Address 2427 Edmondson Ave
(Name not filled in by registrar) Huntington Williams, M.D.

MAR 5 - 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Mar 5 1947, at 1.00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15 1947 to 3/5 1947, and that I last saw h[illegible] alive on 2/20/47

| Immediate cause of death | Duration |
|---|---|
| Myocardial Infarction | 2 weeks |
| Due to Senility | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Helen F Lorenz M. D.
Address 4012 Edmondson Ave Date signed 3/6/47

VS 8

X

G49253

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 52 B

G49253

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Caton Ave & Gwynns Falls
(c) Hospital or institution: Mercy Hospital - 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 Pozon Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Robert O. Byard

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 215-09-1205

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | B | married |

6 (b) Name of husband or wife: Viola Byard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/27/1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 4 8 | 2 1 | hr. min. |

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name James Byard
13. Birthplace South Carolina

MOTHER
14. Maiden Name Viola Hamrick
15. Birthplace South Carolina

16 (a) Informant Viola Howard
(b) Address 1006 N. Pozon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk.
Location Balto. County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) (Date rec'd by registrar) MAR 5 - 1947 (b) Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25th 1947 at 8 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2/24 1947 to 2/25 1947 and that I last saw him alive on 2/25 1947

| Immediate cause of death | Duration |
|---|---|
| Respiratory failure | |
| Due to Carcinoma of bladder | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature August Kiel M. D.
Address Mercy Hospital Date signed 2/28/47

G49254

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46B

G49254 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2521 Francis St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2521 Francis St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Emma Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col.

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Richard L

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6 1877

8. AGE: Years 69 Months 7 Days 25 If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name James Carter
13. Birthplace Md

MOTHER 14. Maiden Name Mary ?
15. Birthplace Md

16 (a) Informant Richard P. Hall
(b) Address 2521 Francis St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 5/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus M. Park
Location Arbutus Md

18 (a) Funeral director Mrs. Ott A. Ellis Dft
(b) Address 112 W. Centre St.

19 (a) 5-1947 (Date rec'd by local registrar) (b) Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 1, 1947, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-30- 1947 to 3-1- 1947.
and that I last saw h~~er~~ alive on 3-1- 1947.

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia | 8 days |
| Due to Carcinoma of Stomach | 8 mos |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Boardman Higgins M.D.
Address 2243 Madison Ave Date signed 3/4/47

VS 150

G49255

G49255

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1310

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 E. Pratt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian B. Trzeciak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife xxxxx late John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 27 1882

8. AGE: Years 64 xxxxx | Months 6 | Days 4 7 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant J. Della Hoel
(b) Address 52 N. Morley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 5/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Hoel
(b) Address 52 N. Morley St.

MAR 5 - 1947 (Date rec'd by Registrar) Huntington Williams M.D. (Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 3 1947, at 12 21 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardiovascular renal disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 3-3-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 181

G49256

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

G49256
Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1807 Vine St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 Vine St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charity Keys
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race Col.
6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Henry Keys
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 25 1884
8. AGE: Years 62 Months 3 Days 7 If less than one day hr. min.
9. Birthplace West River Md. (Town, county, and state)
10. Usual Occupation Nurse
11. Industry or business

FATHER
12. Name John Wilkerson
13. Birthplace West River Md.

MOTHER
14. Maiden Name Mary Johnson
15. Birthplace West River Md.

16 (a) Informant Helen McGovans
(b) Address 1807 Vine St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 6 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cem.
Location A. A. Co. Md.
18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.
19 (a) Date received by registrar 1947 (b) Registrar Huntington Williams M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Mar. 2 1947, at 3P M
21. I certify that death occurred on the date above stated; that I attended deceased from Feb 14 1947 to Mar. 2 1947 and that I last saw her alive on Feb 27 1947

| | Duration |
|---|---|
| Immediate cause of death: Congestive Heart Failure | 2 weeks |
| Due to: Hypertension | 2 yrs |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Douglas Sheppard M. D.
Address 604 N Fulton Ave. Date signed 3/6/47

VS 150

G49257

CWE-106204

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

131a

G49257

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals 26

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 Days

(e) Length of stay in Baltimore (yrs., mos., or days) ?

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. No known Address (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

**3 (a) FULL NAME** John Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | ? |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 ? | | | hr. min. |

9. Birthplace Not known (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Not known

13. Birthplace

MOTHER

14. Maiden Name Not known

15. Birthplace

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 5 1947 (month) (day) (year)

(c) Cemetery or crematory W.F. Auburn Cem.

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St.

19 (a) 1947 (Date filed by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 22 1947, at 8:15P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 5 1947 to Feb. 22 1947, and that I last saw him alive on Feb. 22 1947.

Immediate cause of death Uremia — Duration

Due to Hypertensive C-V-R Disease.

Due to

Other Conditions C-V Accident & c left Hemiplegia.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Herbert R. Farber M. D.

Address Balto City Hosps Date signed 3-22-47

VS 150

G49258 BALTIMORE CITY HEALTH DEPARTMENT G49258

# CERTIFICATE OF DEATH 1310

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2824 Montebello Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2824 Montebello Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** William James Joy
3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Clara D.
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Sept 5 - 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 5 | 22 | hr. min. |

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Caretaker
11. Industry or business Dr Laboratories

FATHER
12. Name John B. Joy
13. Birthplace St. Marys Co. Md

MOTHER
14. Maiden Name Henrietta Parker
15. Birthplace Virginia

16 (a) Informant Clara D. Joy
(b) Address 2824 Montebello Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 1 '47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Maryland

18 (a) Funeral director Edwards & Hayward
(b) Address 3911 Liberty Heights Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 5 - 1947

VS 1M

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 2-27 1947, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1947 to 2-27 1947 and that I last saw h. alive on 2/27 1947

Immediate cause of death: Acute Cardiac Failure — Duration 1 da

Due to: Generalized Arteriosclerosis Cerebral Vascular Renal Disease — Duration 5 yr

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Dight H. Laurkartis M.D.
Address 67 W Washington St Date signed 3/5/47

G49259

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 838

G49259

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1945 W Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Adomas Bukota

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ?

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | W | Widower |

6 (b) Name of husband or wife Veronica
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 27 - 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 2 | 11 | hr. min. |

9. Birthplace Lith (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Joseph Bukata
(b) Address 1945 W Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Joseph Rozanski
(b) Address 609 Washington Blvd

19 (a) Washington Williams, Mortician (Signature of registrar)
MAR 5 1947

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** March 4 1947; 10:22 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1946 to March 4 1947, and that I last saw him alive on March 4 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral Thrombosis | |
| Right partial hemiplegia | |
| Due to Generalized arteriosclerosis | 1 yr |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. S. Remzle
Address 642 Wash Blvd Date signed 3-5-47.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49260

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V94a

G49260 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3119 Fleet Street.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3119 Fleet St. (If rural give location)
(e) Citizen of foreign country? Yes. (Yes or No)
If yes, name country Russia

**3 (a) FULL NAME** ELIA MELNECHUK

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| None | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M. | W. | Widowed |

6 (b) Name of husband or wife Anna Melnechuk
6 (c) If alive, give age deceased years

7. Birth date of deceased (mo., day, yr.) 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | | | hr. min. |

9. Birthplace Kobryn Russia (Town, county, and state)
10. Usual Occupation Steelworker
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Denis Melnechuk
13. Birthplace Russia

MOTHER
14. Maiden Name Elaine (Melnechuk)
15. Birthplace Russia

16 (a) Informant Daniel A. Melnechuk.
(b) Address 1740 N. Potomac St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 - 6 - 47 (month) (day) (year)
(c) Cemetery or crematory Russian cemetery
Location Stony Run P. O. (county)
18 (a) Funeral director John M. Debey
(b) Address 401 S. Chester Street
19 (a) _____ (b) _____ (Date rec'd by registrar)

MAR 5 - 1947

Huntington-Williams Mfg. Co. 95-100

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 3rd 1947, at 6:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to March 3 1947.
and that I last saw him alive on Jan 15 1947.

| Immediate cause of death | Duration |
|---|---|
| Acute Heart failure | 30 Min. |
| Due to Coronary Occlusion | 6 yrs. |
| Due to Hypertension | 6 yrs. |
| Due to arteriosclerosis | |
| Other Conditions None | |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation —
Findings of autopsy None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —
23. Signature A. S. Carpenter M.D.
Address 6410 York Rd Date signed March 3, 47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49261

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 166

Registered No. G49261

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 2
(d) Length of stay in hospital (yrs., mos., or days) Dom.
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 529 N. Cross Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** James A. Harrington

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 43 | | | hr. min. |

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Thomas Harrington
13. Birthplace N. C.

MOTHER
14. Maiden Name Iginah McIver
15. Birthplace N. C.

16 (a) Informant Thomas Harrington
(b) Address 361-W. Preston St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 3/5/47 (month) (day) (year)

(c) Cemetery or crematory
Location Sanford, N. C.

18 (a) Funeral director A. Halstead
(b) Address 918- Lind Hilton

19 (a) Filed by registrar 5-104 (b) Registrar

VS 191

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 1, 1947, at 11 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bullet wound of heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-1-47 at 10:30 P. M.
(b) Where did injury occur? 644 Easton Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature George T. Morrill M.D.
Medical Examiner.
Date signed 3-3-47

Huntington Hillcrest, Md.
Registrar

X

G49262

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1312a

G49262 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4338 Falls Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4338 Falls Road
(If no No., give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Charles Pascoe

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-9146

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Blanche Pascoe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 20-1872

8. AGE: Years 74 | Months 5 | Days 14 | If less than one day hr. min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Poole Engineering & Machine Co

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Anna Elizabeth Jones

(b) Address 4027 Roland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 6-1947 (month) (day) (year)

(c) Cemetery or Crematory St Marys Hamden

Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road Williams, Md

19 (a) (Date rec'd by registrar) (b) Huntingtown Registrar

MAR 5 - 1947

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 4- 1947, at 4 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 2nd 1947, to March 4 1947, and that I last saw h[illegible] alive on March 3 1947.

| | Duration |
|---|---|
| Immediate cause of death: Myocardial Degeneration | 2 days |
| Due to: Cardio Renal Vascular Disease | 10 yrs. |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J M Wilson

Address 617 W. 40th St Date signed 3/5/47 M. D.

X

G49263

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

131a

Registered No. G49263

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3634 Hickory Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3634 Hickory Avenue
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) **FULL NAME** Samuel Edward Chaney

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-05-0491

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Claudia May Chaney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9-1878

8. AGE: Years 68 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace Laurel, Maryland
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business U. Pekyrie Co.

FATHER
12. Name Samuel Chaney
13. Birthplace Maryland

MOTHER
14. Maiden Name Frances —
15. Birthplace Maryland

16 (a) Informant Mrs. Claudia May Chaney
(b) Address 3634 Hickory Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 7-1947 (mo.) (day) (year)

(c) Cemetery or crematory Mt. Moriah Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Burger Funeral Home
(b) Address 3631 Falls Road

19 (a) MAR 5 1947 (Date received by registrar) Williams M.D. (Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 4 1947, at 11:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 24 1945 to Mar 4 1947, and that I last saw him alive on Mar 3 1947.

| | Duration |
|---|---|
| Immediate cause of death: Cardiac decompensation | 6 mos. |
| Due to: Chronic Cardio-Vascular-renal disease | 5 yrs. |
| Due to | |
| Other Conditions — | |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 846 W 36th St Date signed 3/8/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49264

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 486

G49264

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3357 Falls Road
(c) Hospital or institution: 13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3357 Falls Road
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Delta Risner

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Edward C. Risner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29 1896

8. AGE: Years 50 | Months 5 | Days 25 | If less than one day hr. min.

9. Birthplace Caroline Co Virginia
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John M. Howard
13. Birthplace Virginia

MOTHER
14. Maiden Name Irene Grimes
15. Birthplace Virginia

16 (a) Informant Edward C. Risner
(b) Address 3357 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 6-1947 (mo.) (day) (yr.)

(c) Cemetery or crematory Baltimore National
Location Baltimore Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date rec'd by registrar) (b) Hunter for Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 4- 1947, at 4A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to 3-4 1947 and that I last saw her alive on 2-4 1947

Immediate cause of death

| | Duration |
|---|---|
| Carcinoma Uterus | |
| Generalized Carcinomatosis | 1 yr. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence J. Shumate M. D.
Address 317 N Dallard Date signed 3-5-47

VS 150

G49265

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46E

G49265 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3022 Remington Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3022 Remington Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mrs. Sadie Frances Wilson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Alexander Wilson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 19-1879
8. AGE: Years 67 Months 8 Days 15 If less than one day hr. min.
9. Birthplace Becklersville Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Jacob Tracey
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha Caplin
15. Birthplace Maryland

16 (a) Informant Mrs. Ezra M. Knapp
(b) Address 3022 Remington Avenue
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 7-1947 (month) (day) (year)
(c) Cemetery or crematory Pine Grove
Location Rayville, Baltimore Co. Md.
18 (a) Funeral director Burgee Funeral Home
(b) Address 363 Falls Road
19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 7 1947, at 5-15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/7/1945 to 3-4 1947 and that I last saw h[illegible] alive on 3-4 1947

| Immediate cause of death | Duration |
|---|---|
| Respiratory Failure | 1 Day |
| Due to Carcinoma of Cervix | 18 mos. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Weiss, Md M. D.
Address 2902 Huntingdon Ave Date signed 3-5-47

VS 150

G49266

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 95 B

G49266 Registered No.

PRESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Blttimore Gen. 9-14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 513 E. 27th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH I SMITH

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife Margaret M. Pike
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | 5 | 18 20 | hr. min. |

9. Birthplace Catasaqua Penn. (Town, county, and state)
10. Usual Occupation Steel Worker
11. Industry or business

FATHER
12. Name Irvin
13. Birthplace Catasaqua Pa.

MOTHER
14. Maiden Name Sarah Ann Williams
15. Birthplace Catasaqua Pa.

16 (a) Informant Wife
(b) Address 513 E. 27th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/47 (month) (day) (year)
(c) Cemetery or crematory
Location Catasaqua Pa.

18 (a) Funeral director Clarence E. Hoffmann
(b) Address 1639 Broadway.

19 (a) (by registrar) (b) Registrar

MAR 5 1947 Huntingdon Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 5, 1947 at 6 Ea M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/28 1947 to 3/5 1947 and that I last saw h. alive on 3/7 1947.

Immediate cause of death — Duration
Unknown
Due to Subacute Bacterial Endocarditis
Due to Streptococcus Viridans Infection
Other Conditions Rheumatic Heart Disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Heyburn Lang
Address 300 W. North Ave. Date signed 3/6/47 (M/D/Y)

X

AB-107 G49267

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13B G49267

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo- 8days
(e) Length of stay in Baltimore (yrs., mos., or days) 22yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1043 N. Front St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Wilmer Steadman

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-03-6552

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | C | Separated |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9- 1905

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 41 | 8 | 24 | hr. min. |

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Andrew Steadman
13. Birthplace S. C.

MOTHER
14. Maiden Name Marie Bolin
15. Birthplace S. C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Anne Arundel Co. Md.

18 (a) Funeral director Wm. J. Chatman Jr
(b) Address 1701 McCulloh St.

19 (a) (Date rec'd by registrar) (b) Tom Williams, M.D. Registrar

MAR 5 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 5- 1947, at 7.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25 1947 to 3-5- 1947 and that I last saw h- alive on 3-3- 1947.

Immediate cause of death: Tuberculosis, Far-advanced — Duration: 6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Hunt M. D.
Address Balt. City Hall Date signed 3-5-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

G49268 HEALTH DEPARTMENT—CITY OF BALTIMORE G49268

# CERTIFICATE OF DEATH

94a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3012 Bayonne Ave St. 7-4 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Amanda L. Wurzbacher

If U.S. Veteran specify WAR ...

(a) Residence: No. 3012 Bayonne Ave St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. Color or Race | 5. Single, Married, Widowed, or Divorced (write the word) |
|---|---|---|
| F | W | W |

3a. If married, widowed or divorced HUSBAND of (or) WIFE of Frank Wurzbacher

6. DATE OF BIRTH (month, day, year) July 30 1879

| 7. AGE | Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|---|
| | 67 | 7 | 5 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. At home

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore, Md.

FATHER

13. NAME John M. Heidmann

14. BIRTHPLACE (city or town) (State or country) Md.

MOTHER

15. MAIDEN NAME Caroline Grass

16. BIRTHPLACE (city or town) (State or country) Md

17. INFORMANT Wurzbacher Family
(Address) 3012 Bayonne Ave -

18. BURIAL, CREMATION, OR REMOVAL
Place Parkwood Date 3/8 1947

19. UNDERTAKER Leonard J. Cook
(Address) 5305 Harford Road

FILED MAR 5 1947 Huntington Williams Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 3-5- 1947

22. I HEREBY CERTIFY, That I attended deceased from JAN 23 1947 to MAR 5 1947

Last saw her ALIVE on 3-3 - 1947. Death is said to have occurred on the date stated above, at 1:17A m.

The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| ANGINA PECTORIS | JAN 47 |
| CORONORY THROMBOSIS | 3-4-47 |
| | |
| | |
| Other contributory causes of importance: | |
| | |

Was an operation performed? No Date of ...

For what disease or injury? ...

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? No If so, specify ...

(Signed) Walter E. Hayson M. D.

(Address) 4331 Harford Rd.

X

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Entries of all information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49269

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

13B

Reg. No. G49269

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 27
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County
(c) City or town BALTIMORE, 12 (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 ORKNY ROAD (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** EVAN WARFIELD HOOK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: KITTYE M. HOOK
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): FEB 23, 1877

8. AGE: Years 70 | Months 0 | Days 8/11 | If less than one day hr. min.

9. Birthplace: Howard Co - MARYLAND (Town, county, and state)

10. Usual Occupation: INSORANCE BROKER

11. Industry or business

FATHER
12. Name: CHARLES A. HOOK
13. Birthplace: MARYLAND

MOTHER
14. Maiden Name: LOUISE WARFIELD
15. Birthplace: MARYLAND

16 (a) Informant: WIFE
(b) Address: 519 ORKNY ROAD

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-6-47 (month) (day) (year)
(c) Cemetery or crematory
Location: MARSHALL - VA.

18 (a) Funeral director: STEWART & MOWEN COMPANY
(b) Address: (E. F. MOWEN SUC.) 100 N. EUTAW STREET

19 (a) (b) Registrar
(Date rec'd by registrar)

MAR 5 - 1947

Huntington Williams, M.D.

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** MARCH 4 1947, at 9 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from MARCH 3 1947 to MARCH 4 1947 and that I last saw h.IM alive on MARCH 4 1947

| | Duration |
|---|---|
| Immediate cause of death: CARDIAC FAILURE | 3 days |
| Due to: HYPERTENSIVE CARDIO-VASCULAR DISEASE | ? |
| Due to: | |
| Other Conditions: PULMONARY TUBERCULOSIS | ? |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: LaVenia H. Young, M.D. M. D.
Address: Union Memorial Hosp. Date signed Mar 4 1947

937

P.C.J. 12637

G49270

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

161c

Registered No. G49270

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts.
(c) Hospital or institution: Mercy Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 40 Township (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Viola Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/3/47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 2 | hr. min. |

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John R Stewart
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Garzia Cleary
15. Birthplace Kentucky

16 (a) Informant Mother
(b) Address 40 Township - Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

19 MAR 6 - 1947 (Date rec'd by registrar) (c) Huntington Williams, Md Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 3/5 1947, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/3 1947 to 3/5 1947 and that I last saw h[illegible] alive on 3/5 1947.

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia | |
| Due to Erythroblastosis | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 3/3/47
Major findings of operation Transfusion
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature August Kiel M. D.
Address Mercy Hosp. Date signed 3/5/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19271

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 61

Register No. G19271

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 509 Lakewood Avenue
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 509 N. Lakewood Ave
(If rural give location)
(e) Citizen of foreign country? N.D. (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Frederick Brack

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Emma K.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 3 | 19 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Letter Carrier
11. Industry or business U.S. Government

FATHER
12. Name Christian Brack
13. Birthplace Germany

MOTHER
14. Maiden Name Mary
15. Birthplace German

16 (a) Informant Mrs. Emma Brack
(b) Address 509 N. Lakewood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 8-47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetary
Location Woodlawn

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) Mar 8 1947 Huntington Williams M.D. Registrar
Death recd by registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 4, 1947, at 4.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 4, 1947 to March 4, 1947, and that I last saw him alive on March 4, 1947.

| Immediate cause of death | Duration |
|---|---|
| CORONARY THROMBOSIS | 6 HOURS |
| Due to HYPERTENSION ARTERIOSCLEROSIS | 5 YEARS / 5 YEARS |
| Due to DIABETES MELLITUS | 10 YEARS |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benj. B. Thomas M. D.
Address 448 N. Luzerne Ave. Date signed 3-5-47

X

CM 15877

G49272

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G49272 Registered No. 1542

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4900 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 Yrs. 10 Mos. 26 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 927 E. Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** William F. Klees

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | Widowed |

6 (b) Name of husband or wife Maggie L. ( D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN 3- 1859

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 88 | 2 | 4 | hr. min. |

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Tanner
11. Industry or business Unemployed

MOTHER / FATHER
12. Name Henry Klees
13. Birthplace ? Germany
14. Maiden Name Mary (Unknown)
15. Birthplace ? "

16 (a) Informant Records: Baltimore City Hospitals
(b) Address 4900 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/47 (month) (day) (year)
(c) Cemetery or crematory Balto
Location " Md.

18 (a) Funeral director William Bok Inc.
(b) Address 127 St. Paul St.

19 (a) Filed by (b) Huntington Williams, M.D. Registrar
MAR 8 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 5- 1947, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-7 1916 to 3-5 47 and that I last saw him alive on 3-3 1947

Immediate cause of death ? Septicemia.

Due to Abscess of Knee, L.E. c possible osteomyelitis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: As above

| Duration |
|---|
| |
| |
| |
| |
| |

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert R. Faulkner M. D.
Address Balto. City Hosp. Date signed 3-9-47

X

G49273

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G49273

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N. Lexington St.
(c) Hospital or institution:
Aged Women's & Aged Men's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 N. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John Edward Roe

3 (b) If veteran, name war W | 3 (c) Social Security Account No. none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Katherine Kline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26 1872

8. AGE: Years 74 | Months 5 | Days 9 | If less than one day: hr. min.

9. Birthplace Balto Co. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Thomas Bond Roe

FATHER 13. Birthplace

MOTHER 14. Maiden Name Mary Ellen Youge

MOTHER 15. Birthplace

16 (a) Informant Mrs. H. H. D. Read Supt.

(b) Address 1400 N. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/47 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville Md

18 (a) Funeral director Milton Ford Jr

(b) Address 1317 Ford St

19 (a) MAR 6 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 5 1947, at 5:50 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 30 1947 to March 5 1947 and that I last saw him alive on March 1 1947

Immediate cause of death Cardio-Respiratory Failure — Duration

Due to Coronary Thrombosis

Due to Arteriosclerotic Cardio-Vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maryland Edward Day M.D.

Address 4-E-33 St Balto 18 Date signed Mar. 9 1947

VS 130

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49274

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1316

Register No. G49274

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave.
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 14 d.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore
(c) City or town Edgemere
(If outside city, or town limits, write RURAL and give town)
(d) Street No. 2603 Mannor Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

**3 (a) FULL NAME** JEAN ELENOR Kline

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F. | W. | S. |

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 12, 1927

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 19 | 7 | 22 | hr. min. |

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business —

FATHER
12. Name Charles Kline
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Esther McCollip
15. Birthplace Pennsylvania

16 (a) Informant deceased
(b) Address

17 (a) Burial, cremation, or removal (b) Date thereof 3/6/47 (month) (day) (year)
(c) Cemetery or crematory McCLURE
Location McCLURE Pa

18 (a) Funeral director Fulbright York & Joyce
(b) Address 1814 Ford Ave

19 MAR 6 - 1947 (b) Huntington Hollins M.D.
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** March 4, 1947, at 5:24 P.M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1947 to Mar 4, 1947, and that I last saw h. her alive on Mar 4 1947

| Immediate cause of death | Duration |
|---|---|
| Uremia | 2 Days |
| Due to Nephritis & Nephrosis | 1 yr+ |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: Nephrosis

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature G. Allen Moulton
Address Church Home Hospt. Date signed 3/5/47 M. D.

VS 130

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49275 Blk G68618 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 1 + 1a Registered No. G49275

CMK-108830

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) Entire
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Month

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 546 New Pittsburgh Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles Watkins

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 8-1947

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 1 | 24 | hr. min. |

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name August
13. Birthplace Maryland

MOTHER
14. Maiden Name Maria Stevenson
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Cremated (b) Date thereof 3 PM 3-3-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) MAR 6 - 1947 (b) Huntington Williams
(Date received by registrar) Registrar

VS 150

**MEDICAL CERTIFICATION** A

20. DATE OF DEATH March 2 1947, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 2 1947, to March 2 1947, and that I last saw h... alive on March 2 1947.

| Immediate cause of death | Duration |
|---|---|
| Meningitis | |
| Due to Septicemia | 2 days |
| Due to Pneumonia | |
| Other Conditions due to grain mp. bacillus | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilson E. Hughes M. D.
Address Balto City Hosp Date signed Mar 3 47

X

D 49276

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. C49276

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 817 Hamilton Ter
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 Hamilton Ter. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Desiree Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | W. | widow |

6 (b) Name of husband or wife late John E. Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1899

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 47 | 7 | 20 | hr. min. |

9. Birthplace Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name H. K. Peltekian
13. Birthplace Armenia

MOTHER
14. Maiden Name Lucinda Stone
15. Birthplace Md.

16 (a) Informant Mr. H. K. Peltekian
(b) Address 817 Hamilton Ter.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/47 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location 3445 Frederick Rd
18 (a) Funeral director Harry H. Nitkie
(b) Address 401 E Lanvale Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 6 - 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 4 1947, at 1a M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1946 to March 6 1947 and that I last saw h[illegible] alive on March 4 1946

| Immediate cause of death | Duration |
|---|---|
| Uremia - pneumonia terminal | |
| Due to | |
| Due to | |
| Other Condition Multiple Sclerosis | |

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: —
of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence ✓ at ✓ M
(c) Where did injury occur? none (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? none While at work? ✓ (Specify type of place)
(e) Means of injury —

23. Signature Dorothy Truett M. D.
Address 712 Park Ave. Date signed March 5 1947

X

G49277

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH (93)

Registered No. G49277

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address 1514 Division St

(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mon 21 days

(e) Length of stay in Baltimore (yrs., mos., or days) 40

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5407 Green Spring Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

**3 (a) FULL NAME** Maria Bolden

3 (b) If veteran, name war: No

3 (c) Social Security Account No.:

4. Sex: F

5. Color or race: N

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife: Single

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-28-1877

8. AGE: Years 70 | Months 12 | Days 25 | If less than one day hr. min.

9. Birthplace Cambridge, Md (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER

12. Name John Bolden

13. Birthplace Cambridge, Md.

MOTHER

14. Maiden Name Matilda

15. Birthplace Md.

16 (a) Informant Mrs. Joseph Sampson (Friend)

(b) Address 1115 Whitelock St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/47 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem'l. Pk.

Location Balto. County, Md.

18 (a) Funeral director Charles G. Cooper

(b) Address 510-12 N. Carrollton Ave

19 (a) (Date received by Registrar) (b) Registrar's No.

MAR 6 1947 Huntington Williams M.D.

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 3-2 1947, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-3 1947, to 3-2 1947, and that I last saw her alive on 3-2 1947

Immediate cause of death: Congestive Heart Failure — Duration:

Due to: Hypertensive Heart Disease

Due to:

Other Conditions: Gangrene of left foot and leg

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. I. B. Higgins / Thurlete M. D.

Address Provident Hospital Date signed 3-2-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19278

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓937

Registered No. G19278

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2509 Madison Ave
(c) Hospital or institution: 13-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2509 Madison Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Zachariah Jones

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| NO | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | C | Widowed |

6 (b) Name of husband or wife Sophie
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9/15/1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 5 | 15 | hr. min. |

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business

FATHER
12. Name Jas Jones
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Ely Johnson
15. Birthplace Baltimore, Md

16 (a) Informant Dorothy Jones
(b) Address 2509 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md
18 (a) Funeral director Charles G. Cooper
(b) Address 510-512 N. Carrollton Ave

19 (a) (Date rec'd by registrar) MAR 6 1947 (b) H. Turington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** 3/3/47 19 , at 11:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1- 1947 to 3-3- 1947 and that I last saw h- alive on 3-3 19 47

| Immediate cause of death | Duration |
|---|---|
| Coronary Thrombosis | |
| Due to Hypertension | |
| Cardio Vascular Disease | 3 yrs |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis L. Haynes, M.D.
Address 1340 Druid Park Ave Date signed 3-6-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49279

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 200 a

G49279

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Poplar Grove Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** CATHERINE E. BERGEN

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | married |

6 (b) Name of husband or wife Benjamin M. Bergen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 9 | 29 | hrs. min. |

9. Birthplace Chestertown, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name George B. McWhorter
13. Birthplace Md.

MOTHER
14. Maiden Name Lydia -
15. Birthplace -

16 (a) Informant Mrs. August H. Bauer, daughter
(b) Address 1514 Poplar Grove St.

17 (a) Burial (b) Date thereof 3/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) (b) Registrar
(Date rec'd by registrar)

MAR 6 - 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 4, 1947, at 12:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1947 to March 4 1947
and that I last saw her alive on March 4 1947

| Immediate cause of death | Duration |
|---|---|
| Cardiac failure | ? |
| Due to Others Causes unknown | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. E. Schmidt M. D.
Address 2924 Brighton St Date signed 3-5-47

X

G49280

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G49280 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 331 Gwynn Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 331 Gwynn Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** MAMIE E. RUPP

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widow |

6 (b) Name of husband or wife Edward G. Rupp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1862

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 84 | 9 | 23 | hr. min. |

9. Birthplace New York, N. Y. (Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER 12. Name - Benjamin
FATHER 13. Birthplace -

MOTHER 14. Maiden Name -
MOTHER 15. Birthplace -

16 (a) Informant Mr. Wm. R. Rupp
(b) Address 5509 Groveland Ave. 15

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) MAR 6 1947 (Date received by registrar) (b) Registrar

VS 100

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 3, 1947, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1944 to 3/3 1947, and that I last saw her alive on 3/3 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 2/27/47 |
| Due to Hypertensive & | |
| Arteriosclerotic C.V. Disease | 10 yrs? |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hunter E. Robb, M. D.
Address 3629 Edmondson Ave. Date signed 3/4/47

Huntington Williams, Mgr

X

G49281

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓ 83a

Registered No. G49281

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1921 W. Baltimore St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 3
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1921 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** LAURA CAROLINE WATERS

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| none | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Thomas Waters, Jr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | 0 | 0 | hr. min. |

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Alexander Muse
13. Birthplace Wales

MOTHER
14. Maiden Name Elizabeth Beazley
15. Birthplace Va.

16 (a) Informant Mrs. E. Wortham
(b) Address 3034 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 4, 1947, at 7:00a M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-47 1947, to 3-4- 1947, and that I last saw her alive on 3-4- 1947.

| Immediate cause of death | Duration |
|---|---|
| CEREBRAL HEMORRHAGE | 5 wks. |
| DURATION: | |
| Due to HYPERTENSION | 5 yrs. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel D. Monahan M. D.
Address 1945 W. Baltimore St. Date signed 3-5-47

VS 150

MAR 6 - 1947

Registrar Williams, M.D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G49282

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

107

G49282 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2717 Whitney Ave.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-19
(e) Length of stay in Baltimore (yrs., mos., or days) 58 Yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2717 Whitney Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Schmid ✓

3 (b) If veteran, name war ----
3 (c) Social Security Account No. none

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Cecile C. Schmid
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1864

8. AGE: Years 82 | Months 6 | Days 19 | If less than one day hr. min.

9. Birthplace Switzerland (Town, county, and state)
10. Usual Occupation Retired Machinist
11. Industry or business

FATHER
12. Name Kaspar Schmid
13. Birthplace Switzerland

MOTHER
14. Maiden Name Verena Bop
15. Birthplace Switzerland

16 (a) Informant Mrs. Cecile C. Schmid
(b) Address 2717 Whitney Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director D. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 116 MAR 6 - 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 4, 1947, at 6.30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 26 1947 to Mar 3 1947, and that I last saw him alive on Mar 3 1947.

Immediate cause of death — Bronchial Pneumonia
Due to Uremia
Due to
Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 2 Days, 11 Hrs.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel H Helton Jun
Address 6 W Pleasant St Date signed 3/5/47

X

G49283

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

Registered No. G49283

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1211 Light St
(c) Hospital or institution: SIBGH.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 2

**2. USUAL RESIDENCE OF DECEASED:**
(a) State md (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6607 manna Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANTONIETTA ~~GAETO~~ Esposito

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Saverio Esposito
Samuel 6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Nov. 7 1884

8. AGE: Years 62 | Months 3 | Days 26 2/4 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Henry Martino

13. Birthplace Italy

MOTHER 14. Maiden Name Filomena Ferracci

15. Birthplace Italy

16 (a) Informant Saverio Esposito

(b) Address 6607 Marnalye Dundalk Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 8 1947 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca

(b) Address 52 N. Marley St.

19 (a) 3-10-47 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3-5 1947 at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-26 1947 to 3-5 1947 and that I last saw her alive on 3-5 1947

| Immediate cause of death | Duration |
|---|---|
| (a) Cardiac Failure | |
| Due to (b) Cerebral Hemorrhage | |
| Due to (c) Arterio Sclerosis | |
| Other Conditions Hypertension | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard S. Rocca M. D.

Address Locust Bldg Cumberland Md. Date signed 3-7-47

G19284

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 94a

G19284

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: Mercy 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 A
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 714 N. Carrollton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** PAUL A. SKINNER

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-2674

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gertrude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1897

8. AGE: Years 49 | Months 9 | Days 1 | If less than one day hr. min.

9. Birthplace Chicago, Ill.
(town, county, and state)

10. Usual Occupation Elevator dispatcher

11. Industry or business

FATHER
12. Name John Skinner
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Mary ???
15. Birthplace Maryland

16 (a) Informant Mrs. Gertrude F. Skinner
(b) Address 714 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 7, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George A. Hall
(b) Address 1631 Druid Hill Ave.

19 (d) MAR 6 - 1947 (Date rec'd by registrar) at Washington Hollow, Md. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3/3/47 19 , at 10:55 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Weiss M.D.
Medical Examiner.
Date signed 3/4/47

VS 191

G49285

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 107

Registered G49285

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3713 Ednor Road Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3713 Ednor Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: GEORGE FERDINAND SCHUETTE

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: WIDOWER

6 (b) Name of husband or wife: Emilie Schuette

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1864

8. AGE: Years 82 | Months 7 | Days 13 10 | If less than one day hr. min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business: Retired

FATHER
12. Name: Henry Schuette
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Mr. Wm. W. T. Schuette
(b) Address: 3713 Ednor Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/47 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) MAR 6 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION** AM

20. DATE OF DEATH March 3 1947 at 5.15M

21. I certify that death occurred on the date above stated; that I attended deceased from Febr 27 1947 to March 2 1947. and that I last saw h alive on March 1947.

| | Duration |
|---|---|
| Immediate cause of death: Pulmonary Edema | 24 hours |
| Due to: Bronchial Pneumonia | 2 weeks |
| Due to: | |
| Other Conditions: | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Huff Sanders M. D.

Address 100 N Mullen Date signed 3/5/47

VS 190

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-67469 619286

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

937

619286

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 12-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5yrs- 7mos- 18days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1603 Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Harry Sterner or (Harry Sterner)

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-12-7296

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4- 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 11 | 29 | hr. min. |

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Machine Shop

FATHER
12. Name Isaac Sterner or Sterner
13. Birthplace ?

MOTHER
14. Maiden Name Sropohrna Collett
15. Birthplace Maryland

16 (a) Informant Records -Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 6/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Frederick Road

18 (a) Funeral director Edmondson & Donovan
(b) Address 3615-17 Elmhurst Ave

19 (a) (Date rec'd by registrar) (b) Registrar
MAR 6 - 1947 Hunterston Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 3- 1947 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-15 1947 to 1947, and that I last saw h. im alive on 3-3- 1947.

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia. | |
| Due to Pulmonary Tuberculosis | |
| Due to Arteriosclerotic C-V Disease & Failure. | |
| Other Conditions Bronchiectasis | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert R. Farber M. D.
Address Balto. City Hosps. Date signed 3-3-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-96954 G49287

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1313 ✓

Registered No. G49287

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr.-1mo.-2days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 318 E. 20 1/2 Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER BOND (alias) WALTER HARRIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26-1914

8. AGE: Years 32 | Months 6 | Days 7 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Harris
13. Birthplace Idaho

MOTHER
14. Maiden Name Bertha Crumwell
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 7 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Anne Arundel Co
18 (a) Funeral director William J. Jackson
(b) Address 916 Fremont ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 MAR 6 - 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 3- 19 47 at 6.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-31- 19 46 to 3-3- 19 47
and that I last saw h[im] alive on 3-3- 19 47
Immediate cause of death Pulmonary Tuberculosis, Far Advanced — Duration 15 Mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Was autopsy: Refused

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Hunt
Address Balt. City Hospitals Date signed 3-5-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49288 — Bk # F35675 — For Health — BALTIMORE CITY HEALTH DEPARTMENT — CERTIFICATE OF DEATH — 13B — Reg. No. G49288

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1039 Sarah Ann St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1039 Sarah Ann St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Louise R. Tillman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) 9-11-1941

8. AGE: Years 5 | Months 5 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md (Town, county and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name John W. Tillman
13. Birthplace Md

MOTHER 14. Maiden Name Anita Wright
15. Birthplace Md

16 (a) Informant Anita Tillman
(b) Address 1039 Sarah Ann St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 7 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Towson Baltimore Co Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania ave

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

VS 150 MAR 6 - 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 5 1947 at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1947 to March 5 1947 and that I last saw h[illegible] alive on March 5 1947

| Immediate cause of death | Duration |
|---|---|
| Pulmonary tuberculosis | 6 mos. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 3/7/47 M. D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49289 — BALTIMORE CITY HEALTH DEPARTMENT — G49289 Registered No.

# CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1436 Presstman St
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimor (If outside city or town limits, write RURAL and give town)
(d) Street No. 1436 Presstman St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fannie Kelly Lee

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Robert Lee

6 (c) If alive, give age 20 years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1929

8. AGE: Years 17 | Months 3 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Baltimor, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Arthur Kelly, Sr.

13. Birthplace S. C.

MOTHER 14. Maiden Name Bessie Thornton

15. Birthplace Baltimor, Md.

16 (a) Informant Robert Lee

(b) Address 1436 Presstman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 8 47 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem

Location Camp Ground & Md

18 (a) Funeral director William A Jackson

(b) Address 916 Pennsylvania ave

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

MAR 6 - 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-4- 1947, at 1.20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-10-1946 to 3-4- 1947, and that I last saw h... alive on 3-4- 1947

Immediate cause of death: Pulmonary T.B. — Duration: 1 yr.

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George C Page M. D.

Address 1516 N. Mount St. (17) Date signed 3-6-47.

VS 150

X

G49290 BALTIMORE CITY HEALTH DEPARTMENT G49290

# CERTIFICATE OF DEATH 170c

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Lake Ave - Mt. Washington (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Nard Ganty

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16 1890

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | 3 | 20 | hr. min. |

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Gardner

11. Industry or business Boarder College

FATHER
12. Name John W. Beatty
13. Birthplace Pa.

MOTHER
14. Maiden Name Ida M. Leary
15. Birthplace Md.

16 (a) Informant Mrs Bertie Hughes
(b) Address 1227 W. Lake Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof Mar. 8/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18. (a) Funeral director Ehrenfeld & Dorsey
(b) Address 3615-17 Chestnut Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** March 5 1947 at 10 30 P.M.

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Comminuted fracture base of skull Subarachnoid Hemia.

Due to Ruptured pericardium & heart. Hemorrhage into Thorax & abdominal Cavities.

Other Conditions Multiple fractures, lacerations, and bruises.
(Include pregnancy within 3 months of death)

**22.** If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 3-5-47 at 9:30 P.M. Balto. Co.
(b) Where did injury occur? Falls Rd. & Bear Hill
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Pedestrian struck by auto

23. Signature Homer J. Wilson M.D. Medical Examiner.
Date signed 3-6-47

MAR 6 - 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49291

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

G49291 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 932 S.Clinton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 932 S.Clinton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Louisa K.Koch

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | M |

6 (b) Name of husband or wife George W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1872

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 8 | 13 | hr. min. 15 |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation house wife
11. Industry or business

FATHER
12. Name John Sauer
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Kuhn
15. Birthplace Germany

16 (a) Informant Husband
(b) Address 932 S.Clinton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway

19 (a) MAR 6 - 1947 (Date received by registrar) (b) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3-2-47 19 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-1- 1947 to 3-2 1947 and that I last saw h.r. alive on 3-1-47 19

| Immediate cause of death | Duration |
|---|---|
| Arteriosclerotic Hypertensive C.V. Disease | 2-1-47 |
| Due to Chr. Myocarditis | 2-1-47 |
| Due to Coronal coronalis Thrombosis | 2-1-47 |
| Due to Congested Failure | 2-24-47 |

Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation
of autopsy None

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. A. Schumann M. D.
Address 942 S. Eastern Ave Date signed 3-5-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49292
B.C.H. 75692

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 159

Registered No. G49292

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Oliver & Caroline Sts.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 min
(e) Length of stay in Baltimore (yrs., mos., or days) 10 min

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 Gorsuch Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Boy Bourke

3 (b) If veteran, name war | 3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | W | Single |

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/2/47

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | | hr. 10 min. |

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Norman Bourke
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Elizabeth Herman
15. Birthplace Caleffino, Calif.

16 (a) Informant Mother
(b) Address 1602 Gorsuch Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 7, 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Rueb
(b) Address 5305 Harford Rd Balto

19 (a) (Date rec'd by registrar) (b) Registrar

VOID MAR 6 - 1947 Huntington Williams M.D.

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** March 2 1947, at 12:30 P.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw him alive on March 2 1947

Immediate cause of death Cardio-Respiratory failure — Duration
Due to Prematurity
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23.** Signature Wilbur J. Orth, M.D.
Address St. Joseph's Hosp. Date signed 3/2/47

AB-10 G49293

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G49293

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo- 25days
(e) Length of stay in Baltimore (yrs., mos., or days) 4yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2805 Clearview Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Renecca Smith

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Married |

6 (b) Name of husband or wife Susie(Div.)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20-1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | 10 | 15 | hr. min. |

9. Birthplace Ky. (Town, county, and state)
10. Usual Occupation Odd jobs.
11. Industry or business

FATHER
12. Name Richard Smith
13. Birthplace Ky.

MOTHER
14. Maiden Name Chinthy Stilenter
15. Birthplace Ky.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Pk.
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) MAR 6 (Date received by local registrar) (b) 1947 Registrar Huntington Williams, MD

VS 150

**MEDICAL CERTIFICATION** AM

20. DATE OF DEATH March 5- 1947, at 8.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10- 1947, to 3-5- 1947, and that I last saw h 1m alive on 3-5- 1947

| Immediate cause of death | Duration |
|---|---|
| Tuberculosis, Far advanced | 1yr. |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Same

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Hunt
Address Balt. City Hosp. Date signed 3-5-47 M. D.

X

G49294

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

G49294 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1047 Argyle Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1047 Argyle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Samuel David Cole

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Col. | Married |

6 (b) Name of husband or wife Elizabeth Cole

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | - | 14 | hr. min. |

9. Birthplace Balto. Md. (Town, county, or state)

10. Usual Occupation Truck Driver

11. Industry or business

FATHER
12. Name Joseph Cole
13. Birthplace Md.

MOTHER
14. Maiden Name Lavinia Coot
15. Birthplace Md.

16 (a) Informant Lavinia Edwards
(b) Address 904 Sarah Ann St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 6, 194 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Wm. Kate P. Williams
(b) Address 3229 W. Lafayette St.

19 (a) (Date filed by registrar) (b) Registrar

MAR 8

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 19 47, at 4:40 A M

21. I certify that death occurred on the date above stated, that I attended deceased from March 1, 19 47 to March 2 19 47, and that I last saw h[illegible] alive on March 2 19 47.

Immediate cause of death Cerebral Hemorrhage — Duration 2 hr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed [illegible] 1947

G49295

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 927

G49295 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1813 Vine St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 Vine St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lenor Rozell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4 Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Eliza Rozell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 7 | 3 | — hr. — min. |

9. Birthplace No Carolina (Town, county, and state)
10. Usual Occupation Servant
11. Industry or business

FATHER
12. Name Robt Rozell
13. Birthplace No Carolina

MOTHER
14. Maiden Name Mary ?
15. Birthplace No Carolina

16 (a) Informant William Rozell
(b) Address 813 Vine St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 6, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location

18 (a) Funeral director Mrs. Kate F. Williams
(b) Address 3229 W. Lanvale St.

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 8 1946 Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1946 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1946, to March 4 1946
and that I last saw h alive on 19
Immediate cause of death Valvular Disease Heart — Duration
Due to —
Due to —
Other Conditions ?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank Wagner M. D.
Address 3027 Eastern Ave

X Mar 4

G49296

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

170c

G49296
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec. 2
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3305 Matson Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter G. Mentis

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 24-16 5367

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Angela Failla Mentis

6 (a) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1890

8. AGE: Years 56 | Months 10 | Days | If less than one day hr. min.

9. Birthplace Greece
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name George Mentis
13. Birthplace Greece

MOTHER
14. Maiden Name Bessie ?
15. Birthplace Greece

16 (a) Informant Mr. George P. Mentis
(b) Address 3305 Matson street

17 (a) Burial (b) Date thereof 3/8/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director George J. Agnew Funeral Home
(b) Address 418 W. Mt. Royal Ave.

19 (a) 3-6-1947 (Date rec'd by registrar) (b) Gustave Fox Williams M.D. Registrar

VS 191

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 4, 1947, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Rupture of the pulmonary vein with hemorrhage into the pericardium, Hemothorax, bilateral, Rupture of the int. mamary artery; multiple fractures

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 3-4-47 at 2 P. 25/5 M.
(b) Where did injury occur? Pennington Ave. & Patapsco
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
Means of injury: Auto. vs Truck Collision

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 3/5/47

G49297 ✓ G49297

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: 2207 South road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 27-15
(e) Length of stay in Baltimore (yrs., mos., or days):

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: Md. (b) County: ---
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 2207 South road (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country:

**3 (a) FULL NAME:** JOSEPH A. RENEHAN

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| no | none |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | white | Married |

6 (b) Name of husband or wife: Louise Renehan
6 (c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Nov. 18-1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 3 | 16 | hr. min. |

9. Birthplace: Cumberland, Md. (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business: B. & O. Auditor

FATHER
12. Name: Unknown
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Ireland

16 (a) Informant: Mrs. Louise Renehan
(b) Address: 2207 South road, Mt. Wash[illegible]

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3/7/47 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location:

18 (a) Funeral director: Thos. F. Cogan & Son Inc.
(b) Address: 118 N. Mt. Royal Ave

19 (a) [illegible] (Date received by registrar) (b) [illegible] Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: March 4 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24, 1946 to March 4, 1947 and that I last saw h[illegible] alive on March 4, 1947

Immediate cause of death: Acute Myocardial Failure with Cardiac Decompensation — Duration: Minutes

Due to: Degenerative Chronic Myocarditis — 3 Days

Due to: Arteriosclerosis — 2 Yrs

Other Conditions: — ?

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Kenneth K. Hutchinson M.D.
Address: 1528 Park Ave Date signed: March 5 1947

X

G49298

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 10

G49298 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1434 N. Milton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-3
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1434 N. Milton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Jacob Jewell Snyder

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-0541

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Mary M. E. Snyder
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Aug-13-1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 | 6 | 19 22 | hr. min. |

9. Birthplace Baltimore Md. (town, county, and state)

10. Usual Occupation
11. Industry or business Notary Public

FATHER
12. Name James Jewell Snyder
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Adeline Magill
15. Birthplace Balto. Md.

16 (a) Informant Mary M. E. Snyder
(b) Address 1434 N. Milton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March-8-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Belair Rd & Mills Ave

18 (a) Funeral director John C. Mills Inc
(b) Address 2435 E. Oliver St

19 (a) (Date filed by registrar) 1947 (b) Registrar

MAR 8 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 4 - 1947 at M

21. I certify that death occurred on the date above stated, that I attended deceased from 26 Feb 1947 to 4 March 1947 and that I last saw h[illegible] alive on 4 March 1947

Immediate cause of death Pulmonary infarct — Duration 4 hours

Due to Cardiovascular disease, arteriosclerosis

Due to

Other Conditions Pneumonia, lobar, early

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 1513 N. Milton Ave Date signed 5 March 1947

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49299
AB- 108620

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

8 3a

G49299
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13days
(e) Length of stay in Baltimore (yrs., mos., or days) 5yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 228 N. Gilmore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John C. Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | B | Widowed |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-?

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77? | ? | ? | hr. min. |

9. Birthplace West Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

**FATHER**
12. Name ?
13. Birthplace West Virginia ?

**MOTHER**
14. Maiden Name ?
15. Birthplace West Virginia ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 11, 1947 (month) (day) (year)
(c) Cemetery or crematory Evergreen Cemetery
Location Allegany County, Md.

18 (a) Funeral director Joseph A. Tinsley
(b) Address 6 W. Saratoga St.

19 (a) (b)
(Date rec'd) 1947 by Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 5- 1947, at 1.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-22- 1947, to 3-5- 1947, and that I last saw him alive on 3-5- 1947.

| Immediate cause of death | Duration |
|---|---|
| Respiratory Failure | |
| Due to Cerebrovascular Accident Thrombosis | 1 wk. |
| Due to | |
| Other Conditions Unknown | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy? No autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund S. Beacham M. D.
Address Balto City Hosp. Date signed 5 Mar 47

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

649300

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

Registered No. 649300

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2125 W Saratoga St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 - 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2125 W Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Elizabeth Schafer

3 (b) If veteran, name war
3 (f) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 11 1873

8. AGE: Years 73 | Months | Days 21 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business At home

FATHER
12. Name Augustine Schafer
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Connelly
15. Birthplace Md

16 (a) Informant Mrs Paul A Hottig
(b) Address 52 W Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3 (mo.) 7 (day) 47 (year)

(c) Cemetery or crematory Mt Olivet
Location 4700 Old Frederick Road

18 (a) Funeral director John J Cowan Son
(b) Address 904-03 Fallsway

MAR 6 - 1947 (Date rec'd by registrar)

Huntington Williams, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 3/4/1947 at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 26 1947 to March 4 1947 and that I last saw h[illegible] alive on March 4 1947

| Immediate cause of death | Duration |
|---|---|
| Cardiac Failure | |
| Due to Cerebral Hemorrhage | 5 |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Sargent M. D.
Address 1729 W Lombard St Date signed 3/5/47

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

TN. G49301

# CERTIFICATE OF DEATH 1937

Registered No. G49301

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3227 Fleet St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary Kispert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~Wife~~ Anthony

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4th. 1887

8. AGE: Years 60 | Months 2 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frederick Meisel
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Anna ?
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave ( Records )

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/8/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Garner Hill Rd

18 (a) Funeral director Kelly & Kelly
(b) Address 463 N. Gilmor St

19 (a) (Date rec'd by registrar) (b) Registrar

VS MAR 6 - 1947 Huntington Williams, MD

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar/4th.1947 19 , at 6.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar.4/ 1947, to Mar 4th 1947, and that I last saw her alive on Mar.4th 1947.

| Immediate cause of death | Duration |
|---|---|
| Cerebral hemorrhage | |
| Due to Hypertensive Cardio vascular disease | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S.R. Huffman M. D.
Address Baltimore City Hosp. Date signed 3-6-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49302

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

83a

Registered No. G49302

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 932 E. Biddle St.
(c) Hospital or institution: 10

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10da
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 932 E. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Mullan

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-1534

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | White | Widower |

6 (b) Name of husband or wife Mary L. Cullen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 1 | 19 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Teller
11. Industry or business Race Track

FATHER
12. Name John L. Mullan
13. Birthplace Va.

MOTHER
14. Maiden Name Catherine Shay
15. Birthplace Va

16 (a) Informant Mamie Mullan
(b) Address 932 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 7, 1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 800 East Biddle St

MAR 6 - 1947
(Date rec'd by registrar)

(a) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 5 1947; at 11 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, Spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Weaver M.D.
Medical Examiner.
Date signed 3-5-47

VS 181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49303
5-10514

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G49303

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Nebraska (b) County
(c) City or town Grand Island
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1723 W. 12th.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Janet Marie Watson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1946

8. AGE: Years — | Months 8 | Days 10 | If less than one day hr. min.

9. Birthplace Nebraska
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Donald P. Watson
13. Birthplace Nebraska

MOTHER
14. Maiden Name Becky Hauser
15. Birthplace Nebraska

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/6/47 (month) (day) (year)
(c) Cemetery or crematory Grand Island
Location Grand Island, Nebraska

18 (a) Funeral director John A. Mitchell Mortuary
(b) Address 1200 Eutaw Place

19 (a) (Date rec'd by reg.) (b) Huntington Willis, Registrar

VS MAR 6 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 6th 1947, at 11:15 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1947 to Mar 6 1947 and that I last saw h[illegible] alive on Mar 6 1947

Immediate cause of death: Cardiac failure — Duration 10 hrs

Due to: Congenital Heart Disease — Duration Life

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation 3/5/47

Major findings of operation: Pulmonic stenosis

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry L. Bahrenburg
Address Johns Hopkins Hospital Date signed 3/6/47

X

G49301

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

G49304 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County Baltimore
(c) City or town Towson 4 Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 Stevenson Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** FRANCES M. RIER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: SEPARATED

6 (b) Name of husband or wife: Geo. F. Reier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/4/99

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 47 | 9 | 1 | hr. min. |

9. Birthplace (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name Alfred C. Courtney
13. Birthplace Balto.

MOTHER
14. Maiden Name Edith May Hardesty
15. Birthplace Balto.

16 (a) Informant Richard P. Hutchins Jr
(b) Address 516 Echaning Cross Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mch. 8/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park C
Location 3801 Frederick Ave.

18 (a) Funeral director John D. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) Mch 6 1947 (Date received by registrar) Registrar

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 5 1947 at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 5 1947 to Mar 5 1947, and that I last saw h[illegible] alive on 5 Mar 1947

| Immediate cause of death | Duration |
|---|---|
| Coronary Occlusion | |
| Due to Arteriosclerosis | |
| Due to Diabetes Mellitus | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Myocardial Infarct

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward N. Young
Address St. Joseph's Hosp. Date signed 3/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G49305 BALTIMORE CITY HEALTH DEPARTMENT G49305

# CERTIFICATE OF DEATH 46F

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: (a) Baltimore City, Maryland — Maryland General Hosp.
(b) Street address — Howard & Madison
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4207 Granada Ave. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME William Henry Waltz Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mrs Jessie Waltz.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 5/1867

8. AGE: Years 79 | Months 4 | Days - | If less than one day: hr. min.

9. Birthplace Carrolltown Pa (Town, county, and state)

10. Usual Occupation Retired Printer

11. Industry or business

FATHER 12. Name George M Waltz
13. Birthplace Carrolltown Pa

MOTHER 14. Maiden Name Ellen Stoltz
15. Birthplace Carrolltown Pa

16 (a) Informant Jessie A Waltz
(b) Address 4207 Granada Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 10/1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Harry K. Amuscott
(b) Address 4204 Ridgewood Ave

19 (a) (Date received by Registrar) (b) MAR 6 1947

Hunting for William

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3-5 1947 at 10 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-2 1947 to 3-5 1947 and that I last saw him alive on 3-5 1947

Immediate cause of death: Intestinal obstruction — Duration

Due to: Cholecystic-duodenal anastomosis with

Due to: calculous cholecystitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3-2-47

Major findings of operation: large inflammatory mass involving duodenum & stomach

of autopsy as above

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John E Miller M.D.
Address Maryland Gen'l. Hosp. Balto. Md. Date signed 3/6/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49306

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G49306
Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2534 E. Eager St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2534 E. Eager St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** ANNA LOUISE BLINKE

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | married |

6 (b) Name of husband or ~~wife~~ John Blinke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 29, 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 4 | 6 | hr. min. |

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Albert Cademore
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ida High
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. John Blinke - husband
(b) Address 2534 E. Eager Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/37 (month) (day) (year)
(c) Cemetery or crematory ~~XXXX~~ Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) (Date rec'd by registrar) MAR 6 - 1937 (b) Huntingtown Williamsville, Md.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 3-6-37 1937 at 10:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1936 to March 6 1937.
and that I last saw ~~him~~ her alive on March 6 1937.

| Immediate cause of death | Duration |
|---|---|
| Hypertension | |
| Due to Cardiac | 17. |
| Due to Vascular Disease | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fred Pusich M.D.
Address 600 N. Fulton Ave. Baltimore, Md.

G49307

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 184

G49307 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 15
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 North Carey Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** John H Holt

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Male | Colored | Single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/22/1901

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 46 | 0 | 9 | hr. min. |

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Handy Man

11. Industry or business

FATHER — 12. Name William Holt
13. Birthplace Md

MOTHER — 14. Maiden Name Georgeanna Holt
15. Birthplace Md

16 (a) Informant Nannie M. Adkinson
(b) Address 162 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 7 1947 (month) (day) (year)

(c) Cemetery or crematory Mt Zion
Location

18 (a) Funeral director Charles A. Rice
(b) Address 405 N. Calhoun St.

19 (a) 1947 (Date rec'd by registrar) (b) Registrar

Funeral for Williams

VS 191

**MEDICAL CERTIFICATION** 30

**20. DATE OF DEATH** March 3, 1947, at 8 P. M.

**21.** I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bullet wound of abdomen, acute peritonitis, Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 2/22/47 at M.
(b) Where did injury occur? 712 N. Bond Street, East Baltimore Area
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 3-8-47

X

G49308

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G49308

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County: Carroll
(c) City or town: Westminist (If outside city or town limits, write RURAL and give town)
(d) Street No. R. D. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Rill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, (widowed) or divorced.

6 (b) Name of husband or wife: Laura A Rill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 24-1860

8. AGE: Years 86 | Months 3 | Days 12 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired farmer

11. Industry or business

FATHER
12. Name Leonard Rill
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Seipp
15. Birthplace Maryland

16 (a) Informant Mrs Roeck Dumbrowe
(b) Address Manchester Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 9/47 (month) (day) (year)
(c) Cemetery or crematory Wesley
Location Carroll Co. Md

18 (a) Funeral director Edw Stipton
(b) Address Hampstead, Md

19 (a) (b)
(Date received by registrar) MAR 7 1947 Registrar Huntington Williams, M. D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6/ 1947, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/11/47 1947, to 3/6/ 1947, and that I last saw him alive on 3/6/ 1947.

Immediate cause of death: Circulatory Failure ← 2 days
Due to: Hypertensive Cardio-vascular Disease
Due to:
Other Conditions: Post-Op. Examination for B. P. H.
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Lee H. Wilson M. D.
Address Date signed

G49309

BCH G72849

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

159

G49309
Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3723 Wilkens Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 25 minutes

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3723 Wilkens Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Newborn Baby Boy Newcomer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife None
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) 3-4-47
8. AGE: Years — Months — Days — If less than one day — hr. 25 min.
9. Birthplace 3723 Wilkens Ave (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

MOTHER / FATHER
12. Name Donald Nelson Newcomer
13. Birthplace Yorkraun, Pa
14. Maiden Name Virginia Mae Snyder
15. Birthplace Brownsville Pa

16 (a) Informant Virginia Newcomer
(b) Address 3723 Wilkens Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery [illegible] Medical School MAR 5 1947
Location MAR 5 1947

18 (a) Funeral director Commissioner of Health
(b) Address

MAR 7 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1947, at 9:39 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 4 1947, to March 4 1947, and that I last saw him alive on March 4 1947.

Immediate cause of death (Premature) Surveyprenatal development-
Secondary Premature separation of placenta
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

Duration: 24 wks preg. 12 hrs.

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Karl Pass M.D. M. D.
Address 4021 Wilkens Ave Date signed 3-5-47

X

G49310 BC# B70078 509283

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 159

G49310 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1904 Retreat St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Yom Noble Scovens.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male.

5. Color or race: Black.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-3-47.

8. AGE: Years | Months | Days: 27 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name T. Scovens.
13. Birthplace Md.

MOTHER 14. Maiden Name Lorraine Joyer
15. Birthplace md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School
Loc. MAR 4 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 MAR 7 1947 (Date rec'd by Registrar) Hilda Lee Secretary for Williams

**MEDICAL CERTIFICATION** P

20. DATE OF DEATH March - 2 - 1947 at 9.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1947 to March 2 1947, and that I last saw him alive on March 2 1947.

Immediate cause of death: Prematurity -
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

| Duration |
|---|
| |
| |
| |
| |

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philip Thorn M. D.
Address Johns Hopkins Hosp Date signed 2 Mar 47

VS 190

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49311

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 61

Registered No. G49311

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1514 Division
(c) Hospital or institution: Provident Hosp 2°
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1936 Lauretta ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Wm Calvin Cager.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lula
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4-11-1909

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 37 | 10 | 23 | 5 hr. min. |

9. Birthplace A. G. Co Md (Town, county, and state)
10. Usual Occupation Laborer.
11. Industry or business

FATHER
12. Name Wm H Cager.
13. Birthplace Md

MOTHER
14. Maiden Name Cora Spencer
15. Birthplace Md

16 (a) Informant Lula Cager.
(b) Address 1936 Lauretta ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-9-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Annapolis Jct Md
18 (a) Funeral director Williams & Jackson
(b) Address 916 Penna ave
19 (a) (Date rec'd by registrar) (b) Registrar

MAR 7 - 1947

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 3/6 1947, at 4:45 P M

**21.** I certify that death occurred on the date above stated; that I attended deceased from 3/6 1947 to 3/6 1947, and that I last saw him alive on 3/6 1947.

Immediate cause of death Diabetes Mellitus — Duration 2 hrs

Due to Diabetes Mellitus — Duration 2 yrs

Due to — Duration

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23.** Signature James D. Carr M. D.
Address 515 Baker St Date signed 3-6-47

G49312

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 94a

G49312

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution: Mt Sinai Home 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 4613 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Ethel Gann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Morris

6 (c) If married, widowed, or divorced, how long: 40 - 1945 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 69 Months 11 Days 26 If less than one day hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER — 12. Name: Joseph
13. Birthplace: Russia

MOTHER — 14. Maiden Name: Sarah
15. Birthplace: Russia

16 (a) Informant: Louis Gann
(b) Address: 2445 Lakeview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-47 (month) (day) (year)
(c) Cemetery or crematory: United Hebrew
Location: Washington Boulevard

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 1519 E Balto St

19 (a) (Date rec'd by registrar) (b) Registrar: Williams M.D.

VS 150 MAR 7 - 1947

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 3-6-1947 at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/5 1946 to 3/6 1947 and that I last saw h[illegible] alive on 3/6 1947.

Immediate cause of death: Coronary Thrombosis — Duration: 4 days

Due to: Coronary artery Disease — 2 years

Due to: Essential Arteriosclerosis

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: H Williams M.D.
Address: 2316 Eutaw Pl Date signed 3/6/47

X

G49313 Dr# G20427

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

54 B

Reg# G49313

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Union 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2131 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** MARILYN LINK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1945

8. AGE: Years 2 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Hyman Balto

FATHER 13. Birthplace

MOTHER 14. Maiden Name Pauline Balto

MOTHER 15. Birthplace

16 (a) Informant Hyman Link

(b) Address 2131 Linden ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-47 (month) (day) (year)

(c) Cemetery or crematory

Location Hebrew Mt Carmel

18 (a) Funeral director Jack Levin Inc

(b) Address 1409 E Balto St

19 (a) (Date rec'd by registrar) (b) Registrar

MAR 7 1947

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1947 at 1:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 1947 to March 6 1947 and that I last saw h.er alive on March 6 1947

Immediate cause of death? Neuroblastoma of adrenal Medulla — Duration

Due to — Duration

Due to — Duration

Other Conditions Operation Jan 10 1947. (Include pregnancy within 3 months of death) — Duration

Date of operation Jan 10, 1947

Major findings of operation: Neuroblastoma of adrenal medulla

of autopsy: Neuroblastoma

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sydney G. Watson M. D.

Address Sinai Hosp Baltimore Date signed March 7 1947

X

V S 190

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49314

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

94a

G49314

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address: Monument St
(c) Hospital or institution: Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3700 Edgewood Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Meyer Kamoroff

3 (b) If veteran, name war —
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| M | W | M |

6 (b) Name of husband or wife Rebecca
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | | | hr. min. |

9. Birthplace Roumania (Town, county, and state)
10. Usual Occupation grocer
11. Industry or business

FATHER
12. Name Frank
13. Birthplace Roumania

MOTHER
14. Maiden Name Esther
15. Birthplace Roumania

16 (a) Informant David Kamoroff
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-7-47 (month) (day) (year)
(c) Cemetery or crematory Beth Tefiloh
Location Windsor Mill Rd

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 (a) (b)
(Date received by local registrar)

MAR 7 1947

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1947, at 12:00 M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 6, 1947, to March 6, 1947, and that I last saw h[illegible] alive on March 6, 1947.

Immediate cause of death Cardiac failure — Duration

Due to Myocardial infarction

Due to Coronary occlusion

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sidney Green M. D.
Address Sinai Hospital Date signed 3/7/47

X

G49315

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 50

G49315 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1718 W. Lafayette Ave
(c) Hospital or institution: H

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1718 W. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** HATTIE (HARRIETT) KANE TRAVERS

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| F | C | MARRIED |

6 (b) Name of husband or wife Winder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/31/1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 7 | 4 | hr. min. |

9. Birthplace BALTO; Md (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Thomas J. Hilliard
13. Birthplace BALTO; Md

MOTHER
14. Maiden Name HARRIETT A. HARDEN
15. Birthplace BALTO; Md

16 (a) Informant J. JEANETTE GREEN
(b) Address 1718 W. LAFAYETTE AV.

17 (a) BURIAL (b) Date thereof 3/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MT. CALVARY
Location A. A. COUNTY, MD.

18 (a) Funeral director Joseph B. Locke
(b) Address 1304 N. Central Ave

19 (a) (b) Registrar
(Date recd by registrar)
MAR 8 1947 Huntington Williams, M.D.

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** 3/4 1947 at 5:45 A.M.

**21.** I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1947 to March 4 1947 and that I last saw her alive on March 2 1947

Immediate cause of death: Cancer, breast & G.U. metastasis to chest — Duration: 2 yr, 1

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

**23.** Signature George McDonald M. D.
Address 844 N Carey Date signed 3/6/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49316

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

Registered No. G49316

**1. PLACE OF DEATH**

(a) Baltimore City, Maryland

(b) Street address 210 Wilhelm St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2D

(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 210 Wilhelm St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

**3 (a) FULL NAME** Isaac Henry Parks

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~. |
|---|---|---|
| Male | White | Married |

6 (b) Name of ~~husband or~~ wife Annie Parks

6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Feb 20 3 1859

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 88 | 0 | 15 | hr. min. |

9. Birthplace Cambridge Md.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

**FATHER**

12. Name Wm Edward Parks

13. Birthplace Md.

**MOTHER**

14. Maiden Name Mary Wesley

15. Birthplace Md.

16 (a) Informant Mrs Kendall

(b) Address 1 W. Lee St

17 (a) Burial (b) Date thereof 3/8/47
(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Baltimore

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St Paul St.

19 (a) (b)
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 5 March 1947, at 1:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov, 1946, to 5 March 1947, and that I last saw h[illegible] alive on 5 March 1947

| Immediate cause of death | Duration |
|---|---|
| Bronchopneumonia | 36 hrs. |
| Cerebral Hemorrhage | 46 hrs. |
| Due to Hypertensive C-V Disease | |
| Due to Arteriosclerosis | |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Herman H. Baylus M. D.

Address 1600 Wilkens Ave Date signed 5 Mar 47

MAR 7 - 19[illegible] Institution Williams MX

X

G49317

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G49317 / 123

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County .....
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3122 Rosalie Ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

**3 (a) FULL NAME** Caroline Trautwein

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband ~~or wife~~ John Trautwein
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 1 | 15 | .....hr. .....min. |

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name Karl Altdorfer
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown Unknown
15. Birthplace Germany

16 (a) Informant Russell Merriken
(b) Address 3122 Rosalie ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/7/47 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 5, 1947, at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/4/1947 to 3/5/1947 and that I last saw h[er] alive on 3/5/1947.

| Immediate cause of death | Duration |
|---|---|
| Gangrene of Bowel | |
| Due to Mesenteric Thrombosis | |
| Due to Auricular Fibrillation | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation 3/5/47
Major findings of operation: Early gangrene of all of Small bowel
of autopsy .....

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Samuel D. Daly
Address Sinai Hospital Date signed 3/5/47

V S 150
MAR 7 - 1947 Huntington Williams M.D.

G49318

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G49318

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2921 W HANVALE ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2921 W HANVALE ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** CECELIA C FARRELL

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: FEM | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: BARTHOLMEW FARRELL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY-16-1898

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 48 | 7 | 17 | hr. min. |

9. Birthplace BALTIMORE MD
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business —

FATHER
12. Name WILLIAM FOLL
13. Birthplace BALTIMORE MD

MOTHER
14. Maiden Name ANNA SMITH
15. Birthplace BALTIMORE MD

16 (a) Informant BARTHOLMEW FARRELL
(b) Address 2921 W HANVALE ST.

17 (a) BURIAL (b) Date thereof MARCH 8-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR RD BALTO MD

18 (a) Funeral director Bernard C Hasle
(b) Address 121 E West St

19 (a) (Date rec'd by registrar) (b) Registrar
MAR 7 - 1947 Lurington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 5 1947, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/V 1947 to 3-5 1947 and that I last saw h[illegible] alive on 3/5 1947.

| Immediate cause of death | Duration |
|---|---|
| Acute Cardiac Failure | 1 da |
| Due to Bilateral Pulmonary Tuberculosis | 2 yr |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dorothy Lawrence M. D.
Address 6 W Lexington St Date signed 3/7/47

G49319

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1947

Registered No. G49319

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Linden Medicine
(c) Hospital or institution: Maryland General Hosp. H
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 201 W Franklin St (If rural give location)
(e) Citizen of foreign country? — ? — (Yes or No)
If yes, name country

**3 (a) FULL NAME** Chin Poke (Chin Poy) (CHIN POY)

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Male
5. Color or race: Yellow
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: —?— (China)
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) About 1884
8. AGE: Years: about 63 | Months: — | Days: — | If less than one day: hr. min.
9. Birthplace China (town, county, and state)
10. Usual Occupation Laundry
11. Industry or business Self

FATHER
12. Name unknown
13. Birthplace China

MOTHER
14. Maiden Name unknown
15. Birthplace China

16 (a) Informant Geo. Chin (cousin)
(b) Address 322 Park Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-47 (month) (day) (year)
(c) Cemetery or crematory Evergreen
Location Brooklyn, New York
18 (a) Funeral director Sledd & Mordecai
(b) Address 108 W Lanvale Ave
19 (a) MAR 7 1947 (Date received by registrar) (b) Huntingtown, Md. Registrar

VS 191

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 6 19 47 at 3:47 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CUASE OF DEATH
Hypertensive heart disease
Myocardial hypertrophy and degeneration
Due to Pulmonary edema

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George C. Merrill M.D. (Medical Examiner.)
Date signed 3/5/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G49320

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 46E

G49320 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 Bolton st. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country —

3 (a) FULL NAME Eccles, Mary D. (Mary Garsed Eccles)
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex female
5. Color or race white
6 (a) Single, married, widowed, or divorced. single
6 (b) Name of husband or wife None
6 (c) If alive, give age 0 years
7. Birth date of deceased (mo., day, yr.) March 25, 1860
8. AGE: Years 86 Months 11 Days 9 If less than one day hr. min.
9. Birthplace Chester Pennsylvania (Town, county and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Samuel Eccles
13. Birthplace England

MOTHER
14. Maiden Name Amanda Garsed
15. Birthplace England

16 (a) Informant Miss Dorsey Downes
(b) Address 1314 Bolton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Stewart Memorial
(b) Address 1018 W. North Ave.

19 (a) Date received MAR 7 1947 Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3-6-1947 at 12:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-28 1947 to 3-6 1947 and that I last saw her alive on 3-5 1947

| Immediate cause of death | Duration |
|---|---|
| Arteriosclerotic gangrene, left leg | 10 day |
| Due to Generalized arteriosclerosis | |
| Due to | |
| Other Conditions Carcinoma hepatic flexure colon (include pregnancy within 3 months of death) | 3 years |

Date of operation Aug 12 1946
Major findings of operation: Carcinoma hepatic flexure colon
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dorcas L. Embery M. D.
Address Church Home & Hosp. Date signed 3-6-47

Huntington Williams, M.D.

G49321

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 83a

G49321 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 32-E-25th St.
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 32-E-25-St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

**3 (a) FULL NAME** Eliza Ann (Lida) Kennedy

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: none
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) About 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| About 77 | — | — | hr. min. |

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation retired Cleaner
11. Industry or business Balto. Public Schools

| | |
|---|---|
| FATHER 12. Name | John F. Kennedy |
| FATHER 13. Birthplace | probably England |
| MOTHER 14. Maiden Name | Eliza S. Bellin |
| MOTHER 15. Birthplace | England |

16 (a) Informant Miss Gerhardt (friend)
(b) Address 3811 Barrington Rd.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-8-47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn
18 (a) Funeral director Stuart Memorial Co.
(b) Address 108 W. Mosher Ave.
19 (a) (Date rec'd by registrar) (b) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 5 1947 at 1.00 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 20 1946 to March 5 1947, and that I last saw h. alive on March 5 1947

| Immediate cause of death | Duration |
|---|---|
| Cerebral Hemorrhage | 24 hours |
| Due to Arteriosclerosis | 10 yrs. |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
If autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Archibald Dunn M. D.
Address 800 N. 33rd St Date signed 3-5-47

VS 150 MAR 7 - 1947 Huntington Williams, M.D.

X

G49322

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

124 B

G49322 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1517 E 33rd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1517 E 33rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Frederick C Betz

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-14-5235

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W. | Sophia Betz Widow |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20-1864

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 82 | 9 | 15 | hr. min. |

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired Mechanic

11. Industry or business

FATHER — 12. Name Gustav Betz
13. Birthplace Germany

MOTHER — 14. Maiden Name Germany
15. Birthplace

16 (a) Informant David W. Betz
(b) Address 1517 E 33rd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof March 7/1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Ellerich Funeral Home
(b) Address 2008 Orleans St

19 (a) Date rec'd by Local Reg. MAR 7 - 1947 (b) Registrar Huntington Williams

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 5 1947, at 1 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1946 to Mar 5 1947, and that I last saw h[illegible] alive on 3-4 1947

Immediate cause of death: Cirrhosis liver — Duration
Cardio-vascular-renal
Due to disease.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. L. Ewalt Jr.
Address 36 York Ct. Date signed 3/5/47

G49323

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1937

G49323 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1210 Linden Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 33 Years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Gray Hoskins

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| | |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | White | married |

6 (b) Name of husband or wife Isadora Chenoweth Hos
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1860

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 86 | 5 | 29 | hr. min. |

9. Birthplace Wilmington Del.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Canned goods

FATHER
12. Name Cheney Hoskins
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Mary
15. Birthplace Md.

16 (a) Informant H. Stanhope Hoskins
(b) Address 3738 Tudor Arms Ave.

17 (a) Burial (b) Date thereof March 7, 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Friend Cemetery
Location Fallston, Harford Co. Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

MAR 7 - 1947 Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 6 1947, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/27 1947, to 3/6 1947, and that I last saw h[illegible] alive on 3/3 1947.

| Immediate cause of death | Duration |
|---|---|
| Myocardial degeneration | |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. E. Jones M.D.
Address 2818 St. Paul St. Date signed

X

G49324

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 469

Registered No. G49324

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 706 East Biddle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706 East Biddle Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Mary E. Cullen

3 (b) If veteran, name war
3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| female | white | widowed |

6 (b) Name of husband or wife James J. Cullen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April.12.1871

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 10 | 23 | hr. min. |

9. Birthplace Frederick Co. Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Daniel H. Filler
13. Birthplace Md.

MOTHER
14. Maiden Name Virginia E. Snyder
15. Birthplace Md.

16 (a) Informant Mrs. Joseph E. Hughes
(b) Address 4005 Loch Raven Blvd.

17 (a) Burial (b) Date thereof 3/10/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) MAR 7 1947 Registrar

VS 190

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 7th, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

| Immediate cause of death | Duration |
|---|---|
| Pancreatic Carcinoma | 3 mos. |
| Due to | |
| Due to | |
| Other Conditions Hepatic Cirrhosis | 3 mos. |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Kammer, Jr. M.D.
Address 518 Aviadan Ave. Date signed Mar 47

Huntington Williams, M.D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR ENDING

G49325

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH V131a

G49325 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 2117 Denison St.,
(c) Hospital or institution:
Crawford Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 101 Edgevale Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** William Reid FauntLeRoy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary L. FauntLeRoy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1862

8. AGE: Years 84 | Months 10 | Days 25 | If less than one day hr. min.

9. Birthplace Portsmouth, Va.
(Town, county, and state)

10. Usual Occupation Mechinal Engineer

11. Industry or business

FATHER
12. Name Henry FauntLeRoy
13. Birthplace Va.

MOTHER
14. Maiden Name Alberta Reid
15. Birthplace Va.

16 (a) Informant Mrs. Mary L. FauntLeRoy
(b) Address 101 Edgevale Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 8, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director J. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 MAR 7 - 1947 Huntington Williams, M.D.

**MEDICAL CERTIFICATION** 8.00

20. DATE OF DEATH March 6, 1947 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 22nd 1947, to March 6th 1947, and that I last saw him alive on March 4th 1947

| Immediate cause of death | Duration |
|---|---|
| Uremia | |
| Due to Arterio Sclerotic Cardio Vascular Renal | |
| Due to Senility | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Reid FauntLeRoy
Address 410 Medical Arts Bldg Date signed 3/7/47

X

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

# CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 8-22 DAY OF 1963 THE MICROPHOTOGRAPHS APPEARING HEREIN STARTING WITH 46001 AND ENDING WITH 49325 ARE ACCURATE AND COMPLETE REPRODUCTIONS OF THE RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics AS DELIVERED IN THE REGULAR COURSE OF BUSINESS FOR PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC COPY.

CAMERA OPERATOR: Loretta Byrne

# END OF REEL